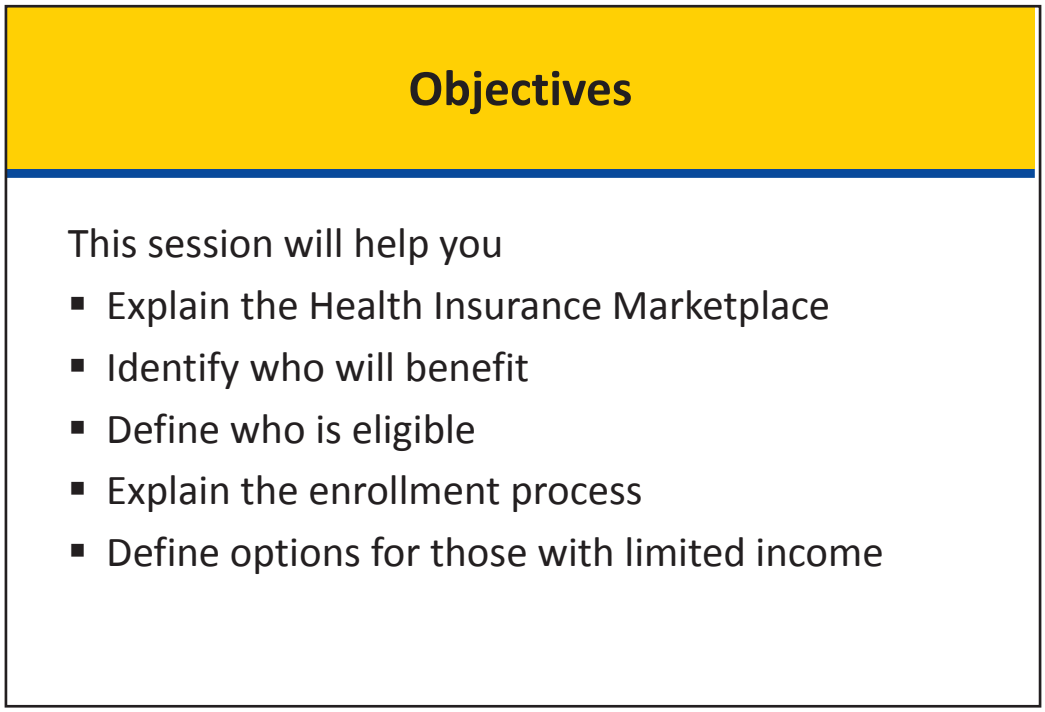
SLIDE TEXT

The Health Insurance Marketplace
March 2013
CMS National Training Program

SPEAKER NOTES:

The Patient Protection and Health Care Law of 2010, amended by the Health Care and Education Reconciliation Act of 2010, are referred to collectively as the "Affordable Care Act." For the purposes of this presentation, we will refer to it as the "Health Care Law."
This session focuses on the new Health Insurance Marketplace (sometimes called "Marketplace" or "Exchange") and other provisions of the Health Care Law.
This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace (also known as Exchanges).
The information in this module was correct as of March 2013.
To check for updates on health care reform, visit http://www.healthcare.gov.
This set of CMS National Training Program materials isn't a legal document. Legal guidance are contained in the relevant statutes, regulations, and rulings.

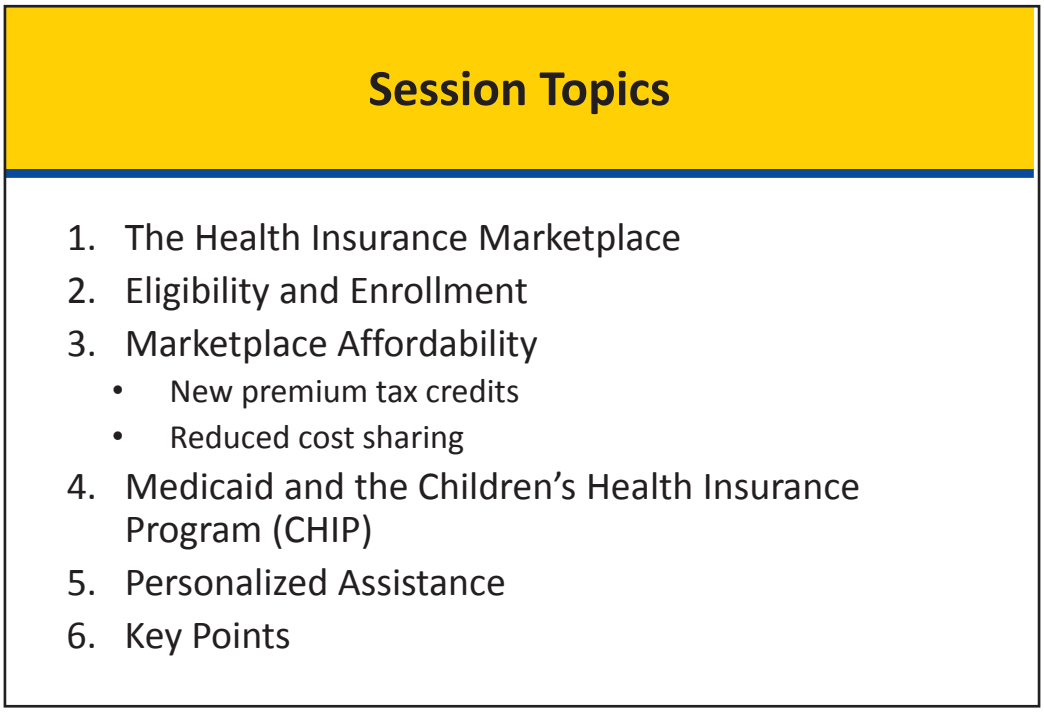


SLIDE TEXT

Objectives
- This session will help you
- Explain the Health Insurance Marketplace
- Identify who will benefit
- Define who is eligible
- Explain the enrollment process
- Define options for those with limited income

SPEAKER NOTES:

This session will help you
- Explain the Health Insurance Marketplace
- Identify who will benefit
- Define who is eligible
- Explain the enrollment process
- Define options for those with limited income



SLIDE TEXT

This session will include the following topics:
1. The Health Insurance Marketplace
2. Eligibility and enrollment
3. Marketplace Affordability
4. New tax credits (advance payment of premium credits)
5. Reduced cost sharing
6. Medicaid and the Children's Health Insurance Program (CHIP)
7. Personalized assistance
8. Key Points

SPEAKER NOTES:

This session will include the following topics:
1. The Health Insurance Marketplace
2. Eligibility and enrollment
3. Marketplace Affordability
4. New tax credits (advance payment of premium credits)
5. Reduced cost sharing
6. Medicaid and the Children's Health Insurance Program (CHIP)
7. Personalized assistance
8. Key Points

SLIDE TEXT

Introduction

New way to buy health insurance when key parts of the health care law take effect

The Health Insurance Marketplace

- Even working families can get help through the Marketplace
- Enrollment starts October 1, 2013
- Coverage begins January 2014

SPEAKER NOTES:

The Marketplace (also known as an Exchange) is for individuals and small employers to directly compare certain competitive private health insurance options, known as Qualified Health Plans, on the basis of price, quality, and other factors. The Marketplace, which will become fully operational by January 1, 2014, will help enhance competition in the health insurance market, improve choice of affordable health insurance, and give small businesses similar options as large businesses.

When key parts of the health care law take effect, there'll be a new way to buy health insurance: the Health Insurance Marketplace.

Enrollment starts October 1, 2013

Coverage begins January 2014

When you shop at the Health Insurance Marketplace, information about prices and benefits is written in simple terms you can understand, so you don't have to guess about your costs. You get a clear picture of what you're paying and what you're getting before you make a choice.

SLIDE TEXT
The Health Insurance Marketplace

To provide individuals and small businesses
- Access to affordable insurance options
- Ability to buy certain private health insurance
- Access to health insurance information

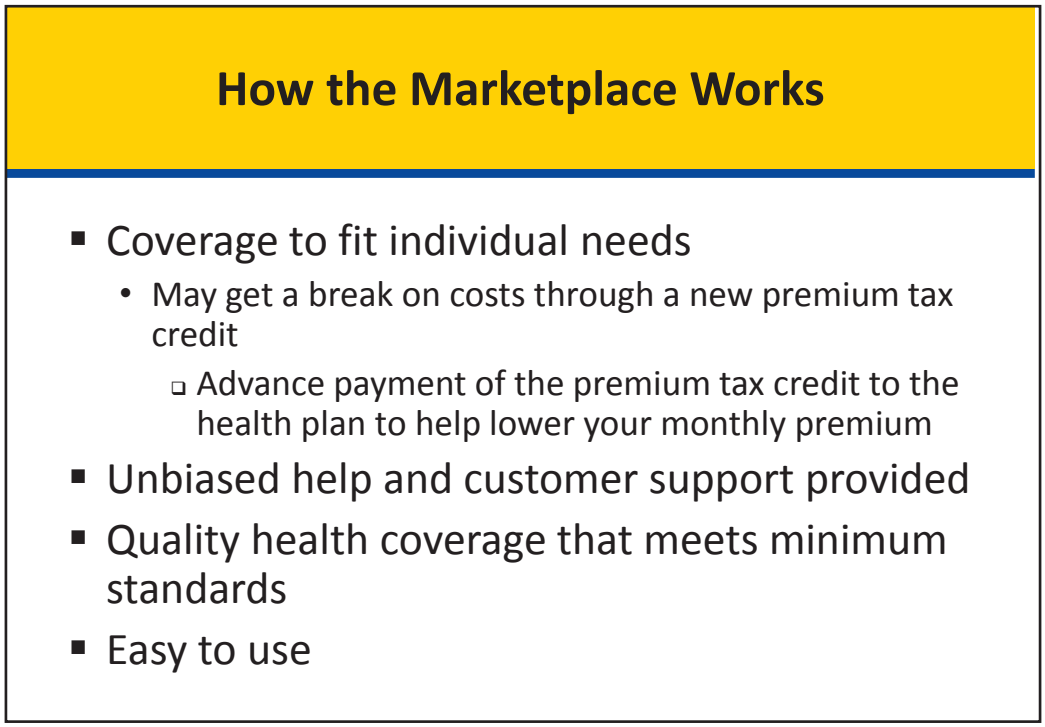
Allows apples-to-apples comparison of Qualified Health Plans

SPEAKER NOTES:

The Health Insurance Marketplace is a new way to find and buy health insurance and apply for Medicaid (discussed later). The Marketplace is designed to help you find health insurance that fits your budget, with less hassle. Eligible individuals and small businesses can shop for affordable, private coverage from Qualified Health Plans.

Qualified Health Plans in the new Marketplace will be sold and run by private companies, and every Qualified Health Plan will cover a core set of benefits called Essential Health Benefits. You'll be able to compare your options based on price, benefits, quality, and other important features. New and expanded programs will be directly linked in, and more people than ever before will get a break on costs. You will have guaranteed coverage and renewability, regardless of a pre-existing condition (like cancer or diabetes), sex, age, etc.

When you shop at the Marketplace, information about prices and benefits is written in simple terms you can understand, so you don't have to guess about your costs. You get a clear picture of what you're paying and what you're getting before you make a choice. Choose a plan from the comfort of your home, or anywhere you can access the Web, and sign up right online. Beginning October 2013, through one application, at one time, you and your family can explore every Qualified Health Plan in your area. You may even be eligible for an advance payment tax credit that lowers your monthly premium right away.



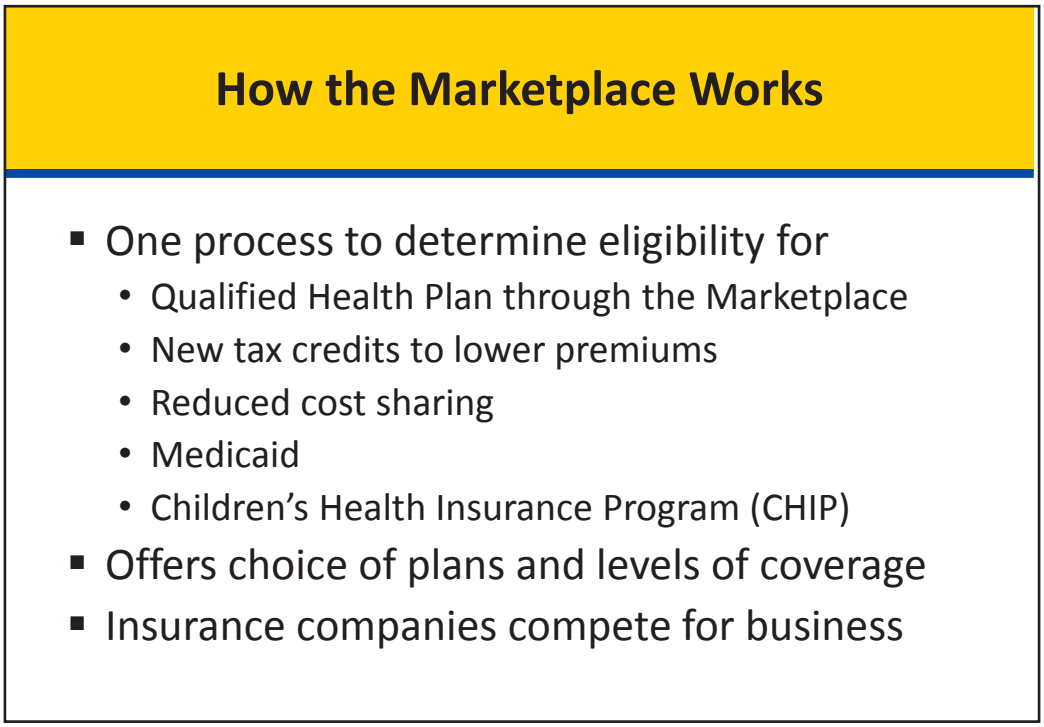
SLIDE TEXT

How the Marketplace Works - Coverage to fit individual needs

- May get a break on costs through a new premium tax credit
- Advance payment of the premium tax credit to the health plan to help lower your monthly premium
- Unbiased help and customer support provided
- Quality health coverage that meets minimum standards
- Easy to use

SPEAKER NOTES:

The Marketplace will make it easier to find insurance coverage that fits your needs by:
Increasing affordability. Find out if you are eligible for advance payment of the premium tax credits, cost-sharing reductions, or public insurance programs to make coverage more affordable.
Offering personalized help. The Marketplace can help you consider your coverage choices and answer your questions. Help will be available through a website, a call center, and community groups or individuals specifically designated as "navigators" to help consumers. Depending on the state, insurance agents and brokers may also be able to help consumers and small employers find coverage options in the Marketplace (if they meet criteria discussed later).
Ensuring quality. The Marketplace will ensure that all Qualified Health Plans in the Marketplace meet basic standards, including quality standards, consumer protections, and access to an adequate range of doctors and clinicians.
Making costs clear. When you shop at the Marketplace, information about prices and benefits is written in simple terms you can understand, so you don't have to guess about your costs. You get a clear picture of what you're paying and what you're getting before you make a choice.
Increasing transparency. The Marketplace will post clear and detailed information about health plan prices, benefits, and quality so that you can make meaningful comparisons between plans.



SLIDE TEXT

How the Marketplace Works

One process to determine eligibility for

- Qualified Health Plan through the Marketplace
- New tax credits to lower premiums
- Reduced cost sharing
- Medicaid
- Children's Health Insurance Program (CHIP)

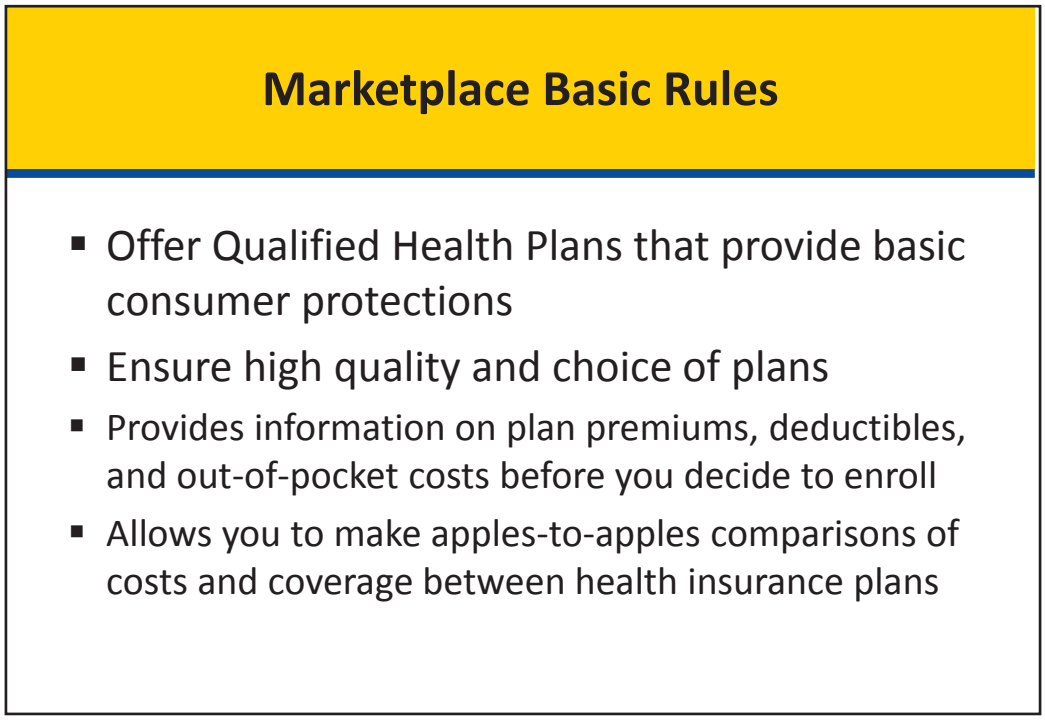
Offers choice of plans and levels of coverage

Insurance companies compete for business

SPEAKER NOTES:

Through the Marketplace, you'll be able to find out if you're eligible for the new tax credits (which you can use right away to lower what you pay for your monthly health plan premium); cost-sharing reductions; or other health insurance programs, like Medicaid (a Federal/State program which covers certain people with low income and resources) and the Children's Health Insurance Program (CHIP) (which covers certain children; and enroll promptly and easily in the appropriate program. One Marketplace application, one time, and you'll see all the programs you qualify for.

The Marketplace offers competition, choice, and clout. Insurance companies will compete for business on a level and transparent playing field, driving down costs.



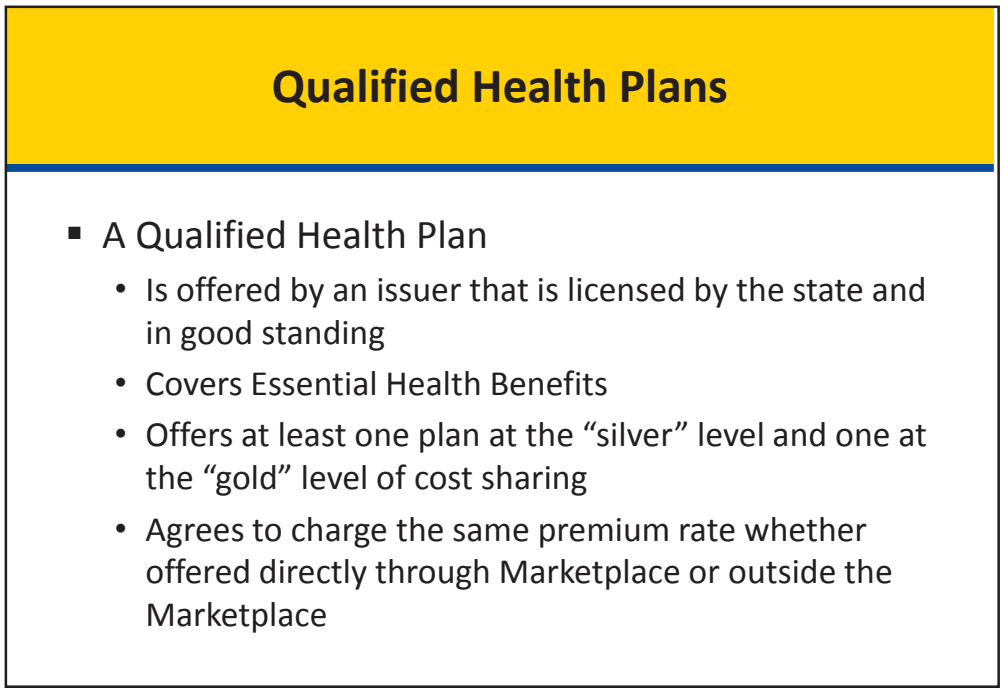
SLIDE TEXT

Marketplace Basic Rules

- Offer Qualified Health Plans that provide basic consumer protections
- Ensure high quality and choice of plans
- Provides information on plan premiums, deductibles, and out-of-pocket costs before you decide to enroll
- Allows you to make apples-to-apples comparisons of costs and coverage between health insurance plans

SPEAKER NOTES:

In order for the Marketplace to operate, it must offer only Qualified Health Plans that meet minimum standards, ensure high quality and a choice of plans to consumers, and cover essential benefits like emergency services, hospitalization, prescription drugs, preventive and wellness services, and maternity and newborn care. Qualified Health Plans provide basic consumer protections. Information will be available on plan premiums, deductibles, and out-of-pocket costs before you decide to enroll. This allows an apples-to-apples comparisons of the costs and coverage between the health insurance plans offered. These are the minimum Federal standards – but states have flexibility in establishing their own Marketplace.



SLIDE TEXT

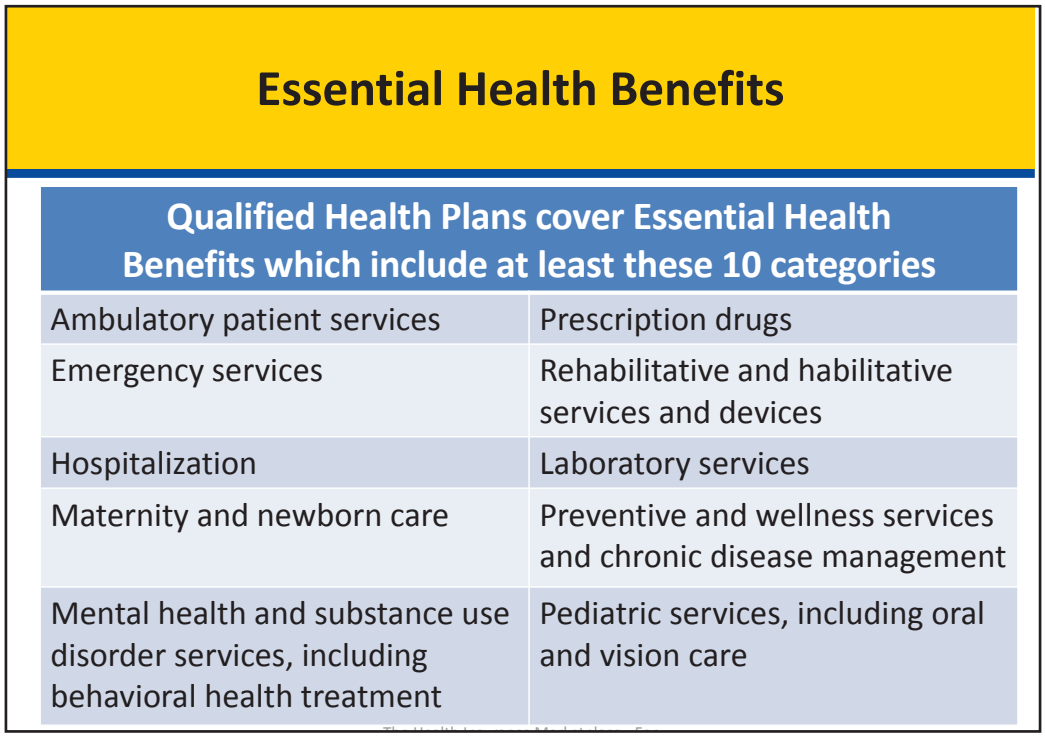
Qualified Health Plans

A Qualified Health Plan

- Is offered by an issuer that is licensed by the state and in good standing
- Covers Essential Health Benefits
- Offers at least one plan at the "silver" level and one at the "gold" level of cost sharing
- Agrees to charge the same premium rate whether offered directly through Marketplace or outside the Marketplace

SPEAKER NOTES:

Section 1301 of the Health Care Law defines Qualified Health Plans as follows:
(a) QUALIFIED HEALTH PLAN.—In this title:
(1) IN GENERAL.—The term ''Qualified Health Plan'' means a health plan that—
(A) has in effect a certification (which may include a seal or other indication of approval) that such plan meets the criteria for certification described in section 1311(c) issued or recognized by each Marketplace through which such plan is offered;
(B) provides the Essential Health Benefits package described in section 1302(a); and
(C) is offered by a health insurance issuer that—
(i) is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage under this title; H. R. 3590—45
(ii) agrees to offer at least one Qualified Health Plan in the silver level and at least one plan in the gold level in each such Marketplace (see slide 11);
(iii) agrees to charge the same premium rate for each Qualified Health Plan of the issuer without regard to whether the plan is offered through an Marketplace or whether the plan is offered directly from the issuer or through an agent; and
(iv) complies with the regulations developed by the Secretary under section 1311(d) and such other requirements as an applicable Marketplace may establish.
The Marketplace can only offer Qualified Health Plans, including stand-alone dental Qualified Health Plans that cover pediatric dental benefits.



SLIDE TEXT

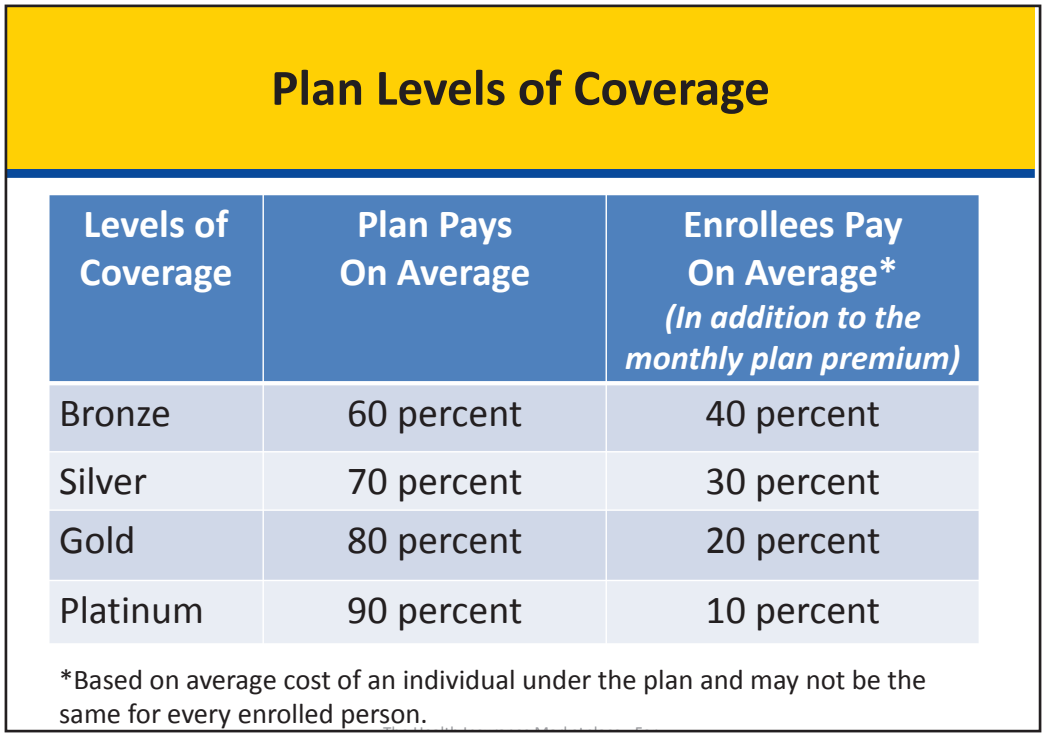
Qualified Health Plans cover Essential Health

Benefits which include at least these 10 categories:

- Ambulatory patient services
- Prescription drugs
- Emergency services
- Rehabilitative and habilitative services and devices
- Hospitalization
- Laboratory services
- Maternity and newborn care
- Preventive and wellness services and chronic disease management
- Mental health and substance use disorder services, including behavioral health treatment
- Pediatric services, including oral and vision care

SPEAKER NOTES:

The Health Care Law provides for the establishment of an Essential Health Benefit (EHB) package that includes coverage of EHBs (as defined by the Secretary of the Department of Health and Human Services (the Secretary)). The law directs that EHBs be equal in scope to the benefits covered by a typical employer plan and cover at least the following 10 general categories: Ambulatory patient services , Prescription drugs, Emergency services, Rehabilitative and habilitative services and devices, Hospitalization, Laboratory services, Maternity and newborn care, Preventive and wellness services and chronic disease management, Pediatric services, including oral and vision care.



Plan Levels of Coverage

Levels of Coverage	Plan Pays On Average	Enrollees Pay On Average* *(In addition to the monthly plan premium)*
Bronze	60 percent	40 percent
Silver	70 percent	30 percent
Gold	80 percent	20 percent
Platinum	90 percent	10 percent

*Based on average cost of an individual under the plan and may not be the same for every enrolled person.

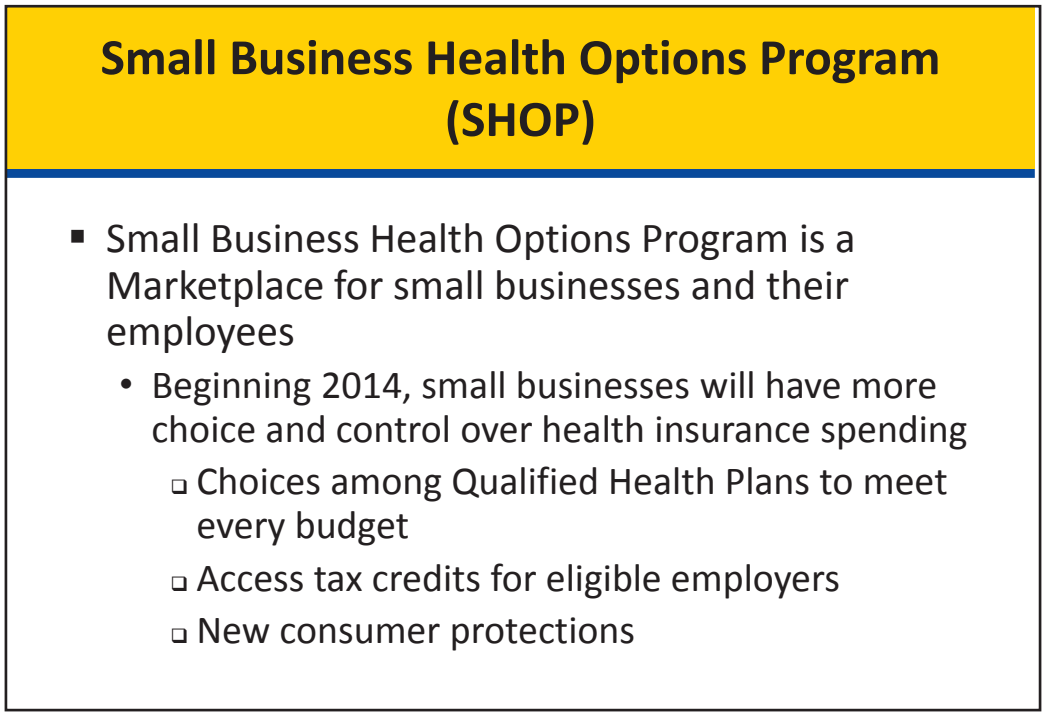
SLIDE TEXT
Plan Levels of Coverage

The following represents the Levels of Coverage, What Plan Pays On Average, What Enrollees Pay. On Average* (In addition to the monthly plan premium) *Based on average cost of an individual under the plan and may not be the same for every enrolled person.

Bronze, 60%, 40%: Silver, 70%, 30%: Gold, 80%, 20%L Platinum, 90%, 10%

SPEAKER NOTES:

Actuarial value, or AV, is a measure of the percentage of expected health care costs a health plan will cover and can be considered a general summary measure of health plan generosity. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy. While premiums are not taken into account to calculate the actuarial value, generally plans with a higher actuarial value and more generous cost-sharing tend to have higher premiums.
The Health Care Law requires that plans meet certain levels of coverage called “metal tiers.” Each of these levels of coverage is associated with an actuarial value, which the statute requires be calculated based on the provision of the Essential Health Benefits to a standard population (and without regard to the population the plan may actually provide benefits to).
The levels of coverage are as follows:
Bronze level - is a health plan that has an AV of 60 percent.
Silver level - is a health plan that has an AV of 70 percent. The Silver plan is used for figuring the reductions in cost sharing and premium tax credits for eligible individuals.
Gold level - is a health plan that has an AV of 80 percent.
Platinum level - is a health plan that has an AV of 90 percent.



SLIDE TEXT
Small Business Health Options Program (SHOP)

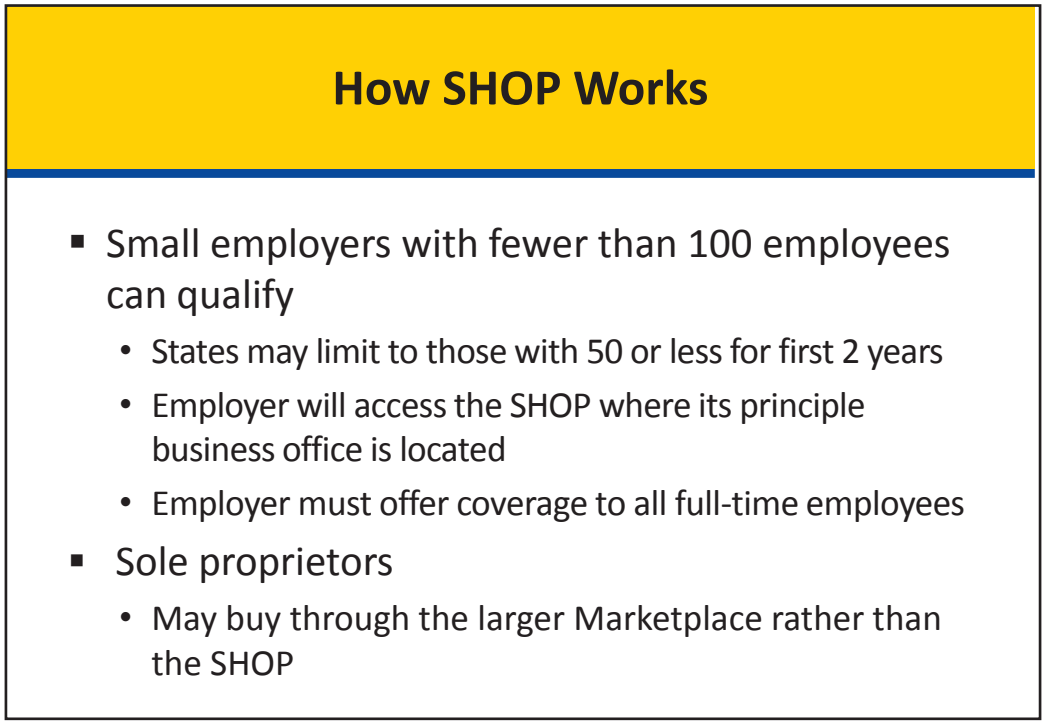
Small Business Health Options Program is a Marketplace for small businesses and their employees

Beginning 2014, small businesses will have more choice and control over health insurance spending

- Choices among Qualified Health Plans to meet every budget
- Access tax credits for eligible employers
- New consumer protections

SPEAKER NOTES:

Today, small employers have a tough time finding and affording coverage that meets the needs of their employees. Starting in 2014, they'll have more choice and control over health insurance spending through the Small Business Health Options Program (SHOP). Eligible employers can choose the level of coverage they offer, define how much they'll contribute toward their employees' coverage, have exclusive access to a small business tax credit, and benefit from new protections that help them get real value for your premium dollars.



SLIDE TEXT

How SHOP Works

Small employers with fewer than 100 employees can qualify

- States may limit to those with 50 or less for first 2 years
- Employer will access the SHOP where its principle business office is located
- Employer must offer coverage to all full-time employees

Sole proprietors

- May buy through the larger Marketplace rather than the SHOP

SPEAKER NOTES:

Small employers must have fewer than 100 employees to be eligible to participate in a SHOP, although states may define a small employer eligible to participate in the SHOP as one with 50 or fewer employees until 2016.

§ 155.710 Eligibility standards for SHOP.

(b) Employer eligibility requirements. An employer is a qualified employer eligible to purchase coverage through a SHOP if such employer—

(1) Is a small employer;

(2) Elects to offer, at a minimum, all full-time employees coverage in a QHP through a SHOP; and

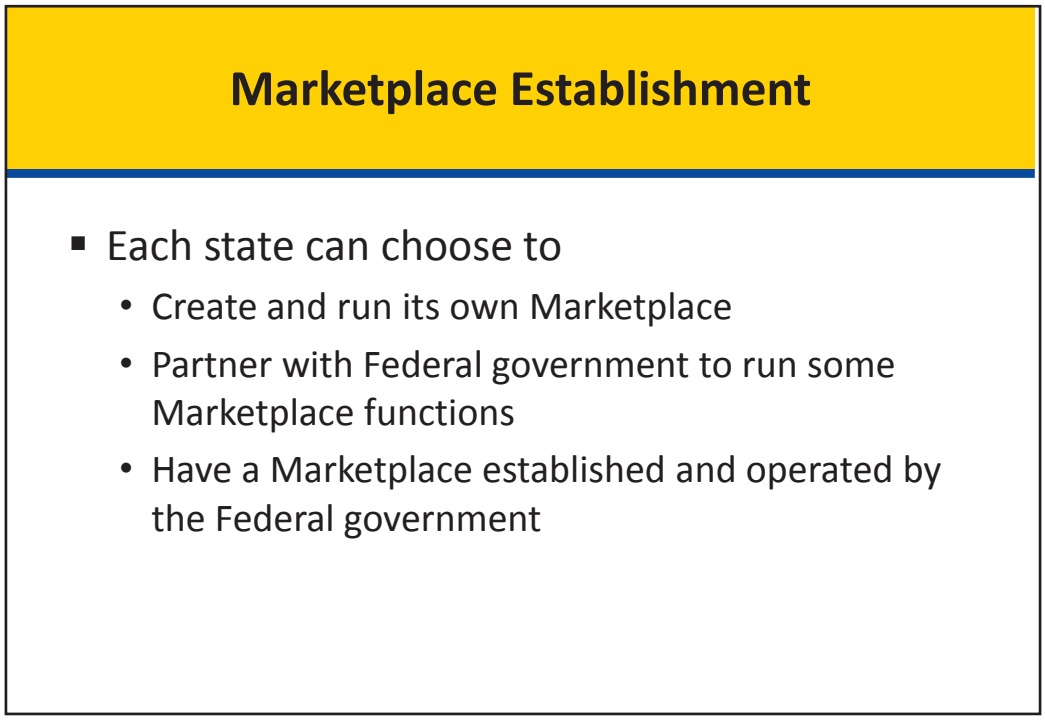
(3) Either—

(i) Has its principal business address in the Marketplace (Exchange) service area and offers coverage to all its full-time employees through that SHOP; or

(ii) Offers coverage to each eligible employee through the SHOP serving that employee's primary worksite.

(c) Participating in multiple SHOPs. If an employer meets the criteria in paragraph (b) of this section and makes the election described in (b)(3)(ii) of this section, a SHOP shall allow the employer to offer coverage to those employees whose primary worksite is in the SHOP's service area.

Those who are sole proprietors are considered individuals and may buy through the Marketplace, but not through a SHOP.

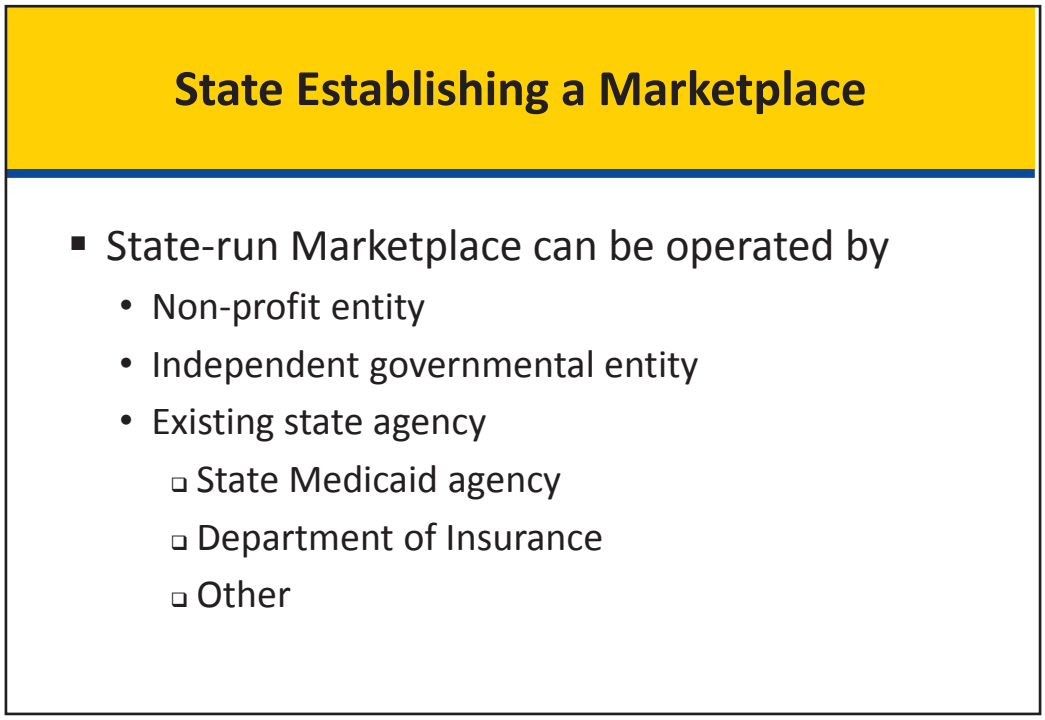


SLIDE TEXT
Marketplace Establishment

Each state can choose to
- Create and run its own Marketplace
- Partner with Federal government to run some Marketplace functions
- Have a Marketplace established and operated by the Federal government

SPEAKER NOTES:

A state has substantial flexibility in establishing a Marketplace that meets the needs of its citizens. States across the country have received grants to establish new Marketplaces. States may create and operate their own Marketplace or participate in a hybrid called a Partnership in which the state runs certain activities for the Marketplace operated by the Federal government. A Partnership Marketplace allows states to make recommendations for key decisions and help tailor the Marketplace to local needs and market conditions. The Federal government will establish and operate a Marketplace in those states that do not establish their own. Some states that decided to operate their own Marketplace submitted a letter of intent and an application. States may also apply to participate in a State Partnership Marketplace with the Federal government by February 15, 2013. States may apply at any time to run their own Marketplace in future years.

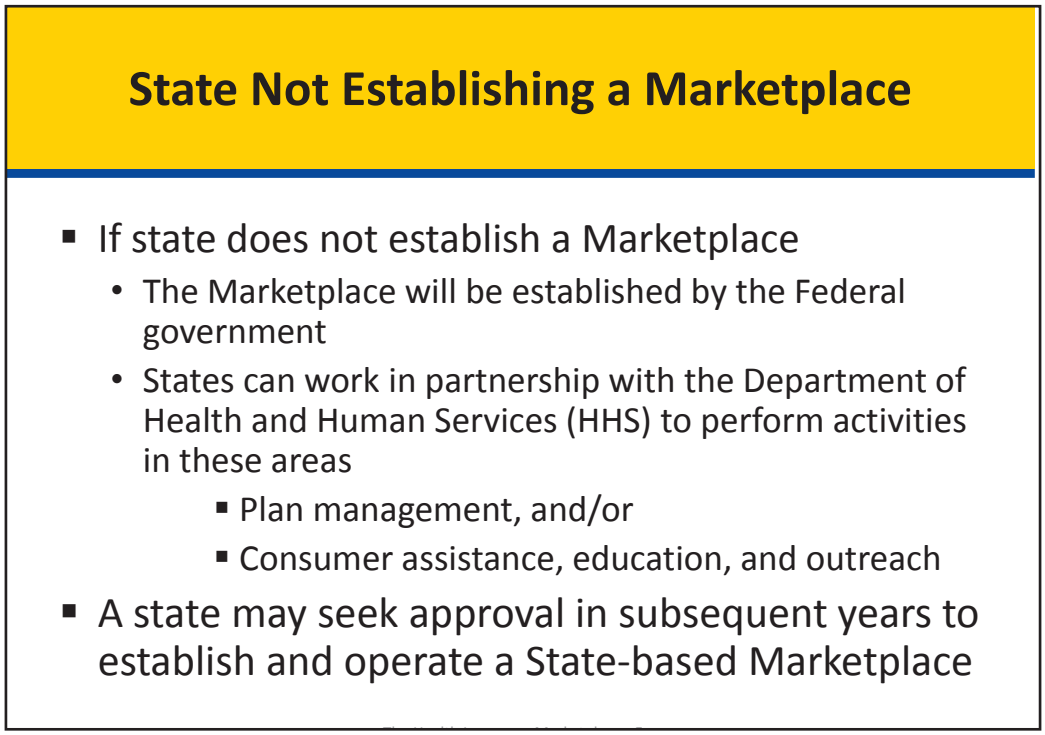


SLIDE TEXT
State Establishing a Marketplace

State-run Marketplace can be operated by
Non-profit entity
- Independent governmental entity
- Existing state agency
  - State Medicaid agency
  - Department of Insurance
  - Other

SPEAKER NOTES:

A state can operate a Marketplace as a non-profit entity established by the state, as an independent public agency, or as part of an existing state agency. Marketplaces that are run by independent agencies or non-profits must have governance principles, include consumer representation, and ensure freedom from conflicts of interest and promote ethical and financial disclosure standards.



SLIDE TEXT
State Not Establishing a Marketplace

If state does not establish a Marketplace The Marketplace will be established by the Federal government
- States can work in partnership with the Department of Health and Human Services (HHS) to perform activities in these areas
  - Plan management, and/or Consumer assistance, education, and outreach

A state may seek approval in subsequent years to establish and operate a State-based Marketplace

SPEAKER NOTES:
If a state chooses not to create and run their own Marketplace:
The Marketplace will be established by the Federal government.
The state can work with the Department of Health and Human Services to perform activities in these areas:
Plan management, and/or
Consumer assistance, education, and outreach
States may apply at any time to run their own Marketplace in future years. A state electing to seek approval of its Marketplace later than January 1, 2013, must have in effect, an approved, or conditionally approved, Marketplace Blueprint and operational readiness assessment at least 12 months prior to the Marketplace first effective date of coverage, and develop a plan jointly with HHS to facilitate the transition to a state Marketplace

SLIDE TEXT
Marketplace Establishment

Federal support for initial costs

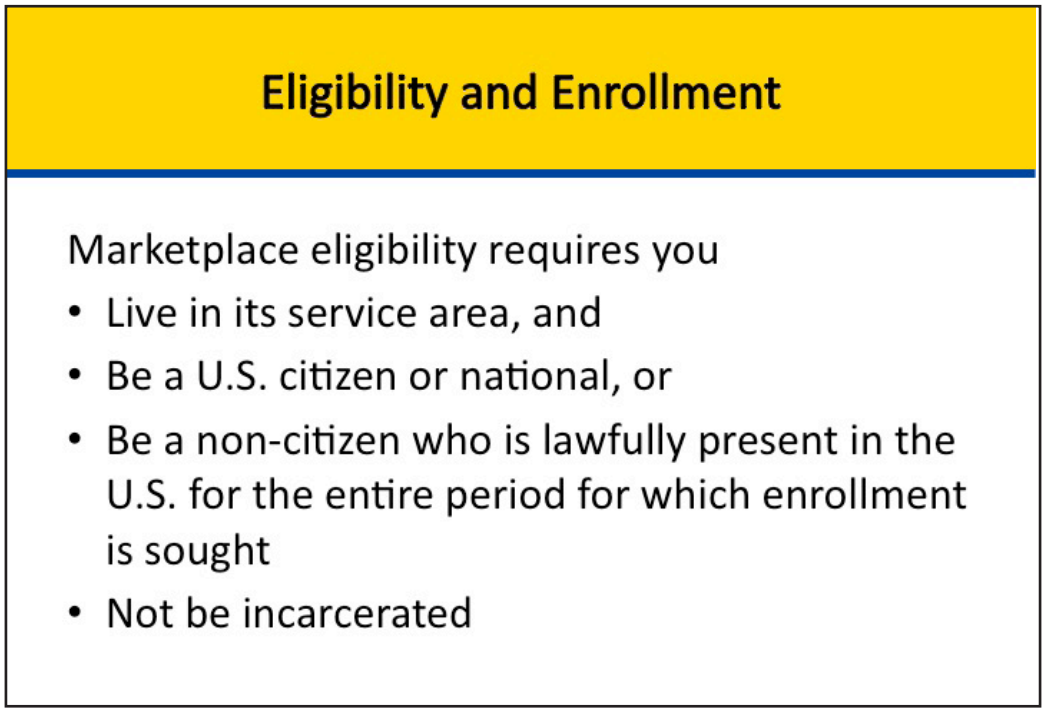
- Federal grants available to states to plan for and establish Marketplace
- Grants must be awarded before January 1, 2015, but are available for establishing Marketplaces until expended
- After January 1, 2015
  - No grants awarded for operational costs
  - Marketplace will be financially self-sustaining

SPEAKER NOTES:

The costs to states for establishing a Marketplace and testing Marketplace operations during 2014 may be funded by grants under section 1311(a) of the Health Care Law. Additionally, grants under section 1311 may be awarded until December 31, 2014, for approved establishment activities that fund first year start-up activities (i.e., activities in 2014 within the applicable grant award).

A state may also receive grants for activities to establish and test functions that the state performs in support of a Marketplace established by the Federal government, including for a State Partnership Marketplace. Generally, states will not be required to repay funds, provided funds are used for activities approved in the grant and cooperative agreement awards. By law, states operating a Marketplace in 2014 must ensure that their Marketplaces are financially self-sustaining by January 1, 2015.

NOTE: Navigators may not be paid through these grants, but through operational funds.

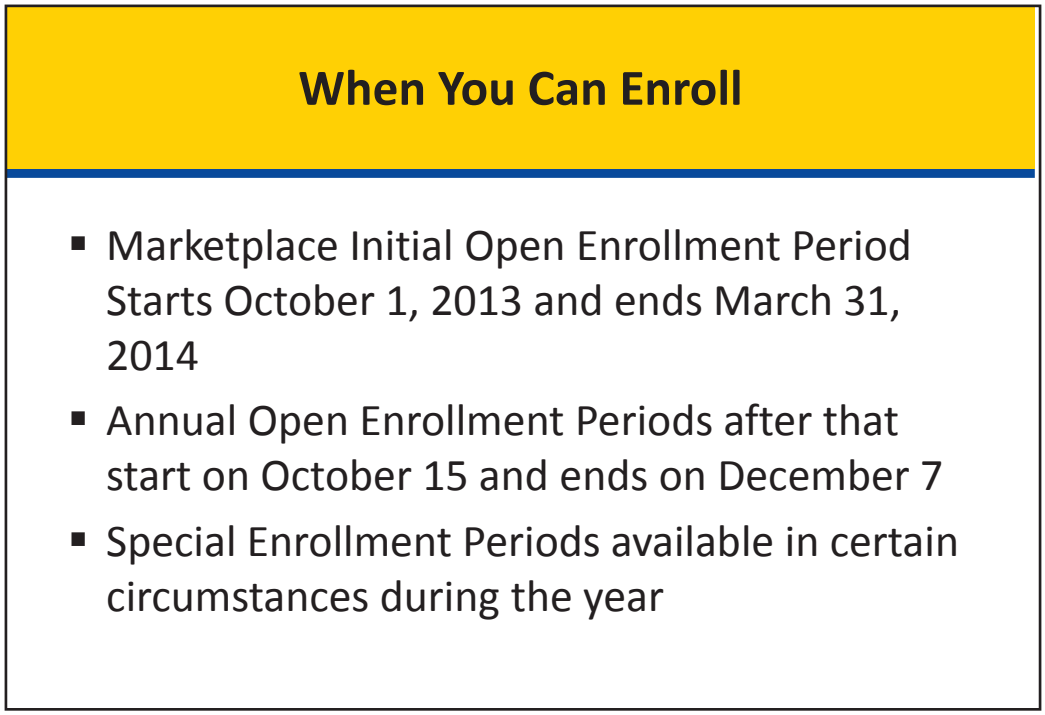


SLIDE TEXT
Eligibility and Enrollment

Marketplace eligibility requires you
- Live in its service area, and
- Be a U.S. citizen or national, or
- Be a non-citizen who is lawfully present in the U.S. for the entire period for which enrollment is sought
- Not be incarcerated

SPEAKER NOTES:

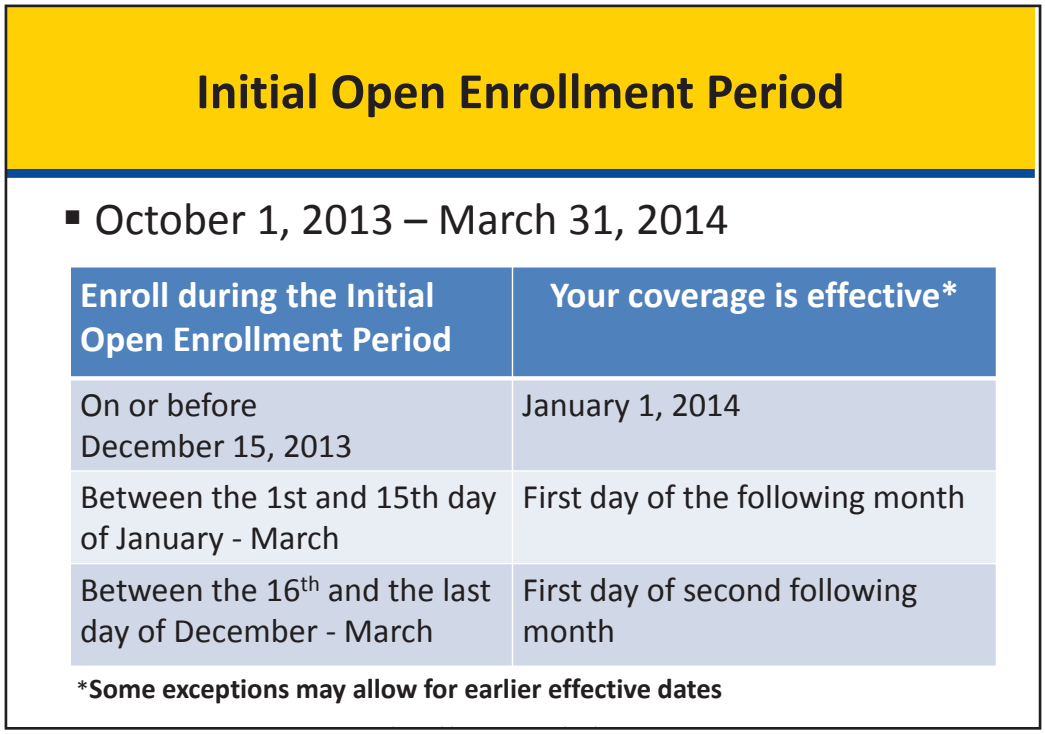
The Marketplace must determine an applicant eligible for enrollment in a Qualified Health Plan (QHP) through the Marketplace if he or she meets the following requirements:
Meets the applicable residence standard—lives in the state served by the Marketplace, or if different, the service area of the Marketplace.
Citizenship, status as a national, or lawful presence. Is a citizen or national of the United States, or is a non-citizen who is lawfully present in the United States, and is reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought.
Is not incarcerated, other than incarceration pending the disposition of charges.
NOTE: If you meet the eligibility requirements you are considered a "Qualified Individual."



SLIDE TEXT
When You Can Enroll

- Marketplace Initial Open Enrollment Period Starts October 1, 2013 and ends March 31, 2014
- Annual Open Enrollment Periods after that start on October 15 and ends on December 7
- Special Enrollment Periods available in certain circumstances during the year

SPEAKER NOTES:
The Marketplace may only permit a qualified individual to enroll in a Qualified Health Plan (QHP) or an enrollee to change QHPs during the Initial Open Enrollment Period, the Annual Open Enrollment Period, or a Special Enrollment Period for which the qualified individual has been determined eligible.
NOTE: Later in the presentation we will discuss Medicaid and the Children's Health Insurance Program (CHIP). You can apply for these programs at anytime.
Annual Open Enrollment Period
For the 2015 benefit period and beyond, the Annual Open Enrollment Period begins October 15 and extends through December 7 of the preceding calendar year. For example, on October 15, 2014, qualified individuals can begin enrolling in coverage that will start on January 1, 2015.
Automatic enrollment
The Marketplace may automatically enroll qualified individuals, at such time and in such manner as HHS may specify, and subject to the Marketplace demonstrating to HHS that it has good cause to perform such automatic enrollments.
Notice of Annual Open Enrollment Period
Starting in 2014, the Marketplace must provide a written Annual Open Enrollment notification to each enrollee no earlier than September 1, and no later than September 30.



SLIDE TEXT

Initial Open Enrollment Period: October 1, 2013 – March 31, 2014

- Enroll during the Initial Open Enrollment Period. On or before
- December 15, 2013, your coverage period is effective January 1, 2014. Some exceptions may allow for earlier effective dates.
- Enroll between the 1st and 15th day of January – March, your coverage is effective First day of the following month
- Enroll between the 16th and the last day of December - March, your coverage is effective first day of second following month.

SPEAKER NOTES:

The Initial Open Enrollment Period begins October 1, 2013 and extends through March 31, 2014. If the Marketplace receives a Qualified Health Plan (QHP) selection from a qualified individual--

From October 1 to December 15, 2013, the Marketplace must ensure an effective date of coverage of January 1, 2014.

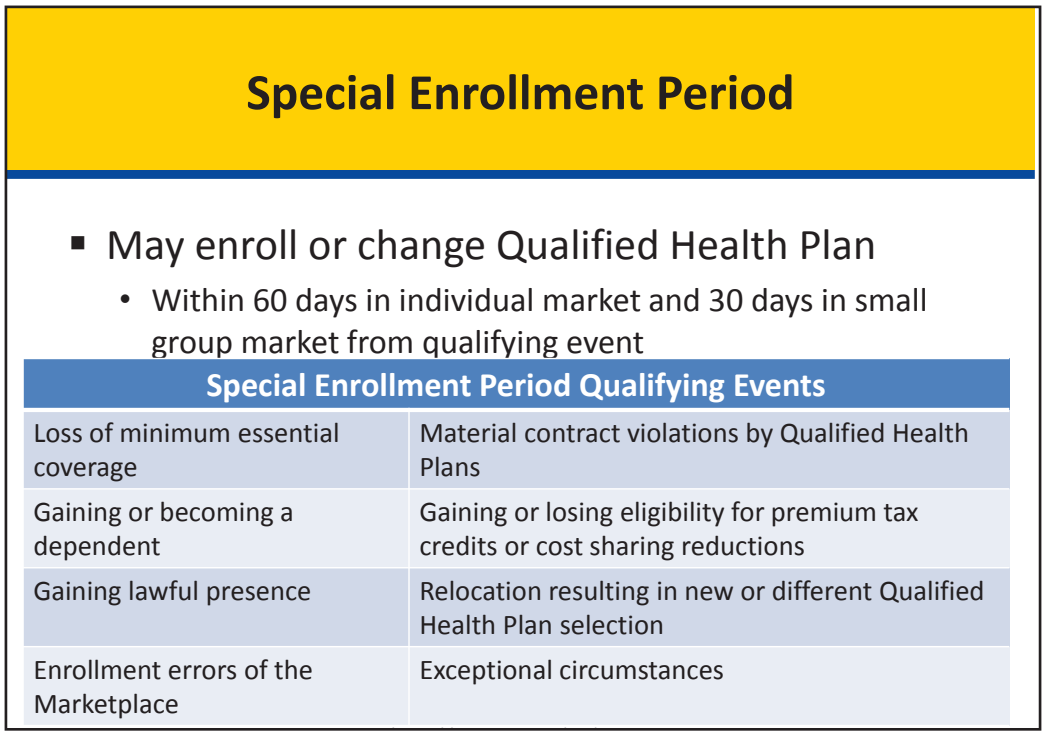
Between the first and fifteenth day of any subsequent month during the Initial Open Enrollment Period, the Marketplace must ensure an effective date of coverage of the first day of the following month.

Between the sixteenth and last day of the month for any month between December 2013 and March 31, 2014, the Marketplace must ensure an effective date of coverage of the first day of the second following month.

The Marketplace has an option to allow for earlier effective dates. Subject to the Marketplace demonstrating to HHS that all of its participating QHP issuers agree to effectuate coverage in a timeframe shorter than mentioned above, the Marketplace may do one or both of the following for all applicable individuals:

For a QHP selection received from a qualified individual the Marketplace may provide an earlier effective date, provided that either— (A) The qualified individual has not been determined eligible for advance payments of the new tax credit or cost-sharing reductions; or (B) The qualified individual pays the entire premium for the first partial month of coverage as well as all cost sharing.

For a QHP selection received by the Marketplace from a qualified individual on a date set by the Marketplace after the fifteenth of the month for any month between December 2013 and March 31, 2014, the Marketplace may provide an effective date of coverage of the first of the following month.



SLIDE TEXT

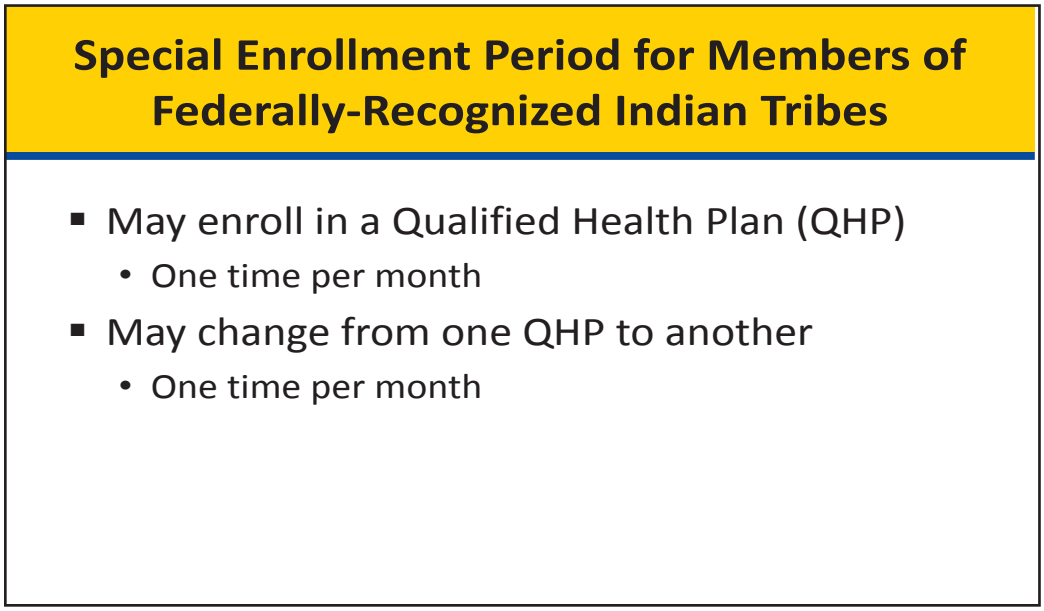
Special Enrollment Period: Within 60 days in individual market and 30 days in small group market from qualifying event:

- Special Enrollment Period Qualifying Events
- Loss of minimum essential coverage
- Material contract violations by Qualified Health Plans
- Gaining or becoming a dependent
- Gaining or losing eligibility for premium tax credits or cost sharing reductions
- Gaining lawful presence
- Relocation resulting in new or different Qualified Health Plan selection
- Enrollment errors of the Marketplace
- Exceptional circumstances

SPEAKER NOTES:

The Marketplace must allow qualified individuals and enrollees to enroll in a Qualified Health Plan (QHP) or change from one QHP to another as a result of the following qualifying events:

(1) A qualified individual or dependent loses minimum essential coverage (such as Government sponsored programs (i.e. Medicare, Medicaid, VA etc.), employer—sponsored plan, plans in the individual market, grandfathered health plans, and other coverage such as State health benefits risk pools) (not including termination or loss due to failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or an act, practice, or omission that constitutes fraud). (2) A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption; (3) An individual, who was not previously a citizen, national, or lawfully present individual gains such status; (4) A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error, misrepresentation, or inaction of an officer, employee, or agent of the Marketplace or HHS, or its instrumentalities as evaluated and determined by the Marketplace. In such cases, the Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction. (5) An enrollee adequately demonstrates to the Marketplace that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee; (6) An individual is determined newly eligible or newly ineligible for a new tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP. The Marketplace must permit individuals whose existing coverage, through an eligible employer sponsored plan, will no longer be affordable or provide minimum value for his or her employer's upcoming plan year, to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan; (7) A qualified individual or enrollee gains access to new QHPs as a result of a permanent move; and (8) A qualified individual or enrollee demonstrates to the Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Marketplace may provide. The SEP lasts 60 days from qualifying event.



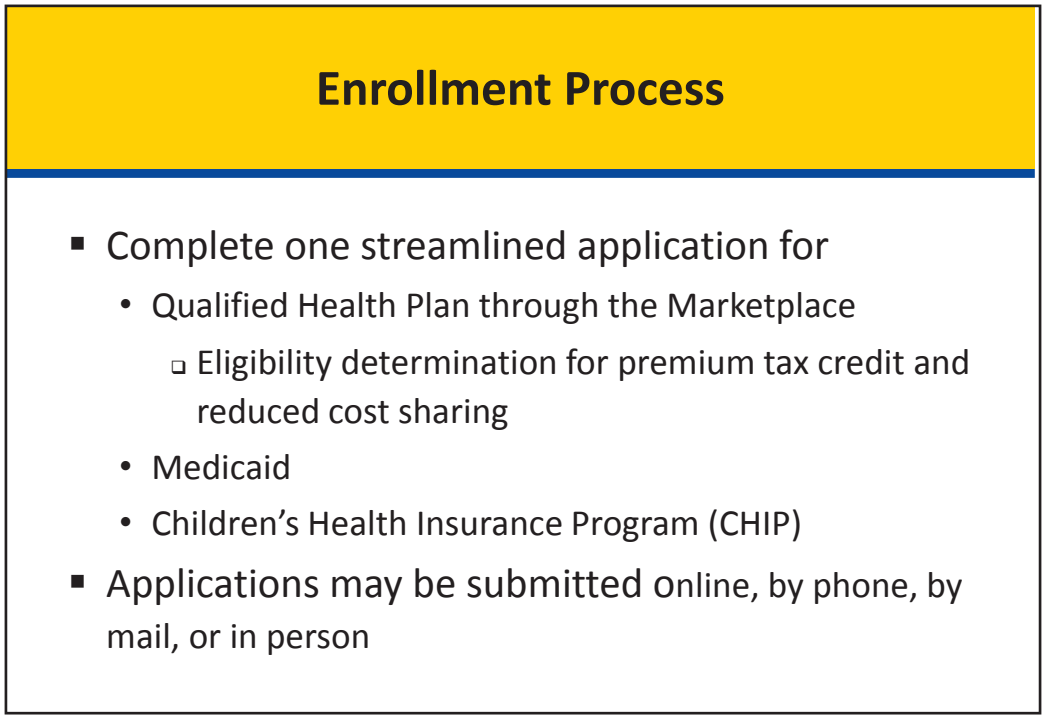
SLIDE TEXT

Special Enrollment Period for Members of Federally-Recognized Indian Tribes

- May enroll in a Qualified Health Plan (QHP)
- One time per month
- May change from one QHP to another
- One time per month

SPEAKER NOTES:

The Health Care Law also includes the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA), which extends current law and authorizes new programs and services within the Indian Health Service (IHS), and provides unique provisions for Indians, including Special Enrollment Periods. An Indian, as defined by Section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan (QHP) or change from one plan to another one time per month.



SLIDE TEXT

Enrollment Process

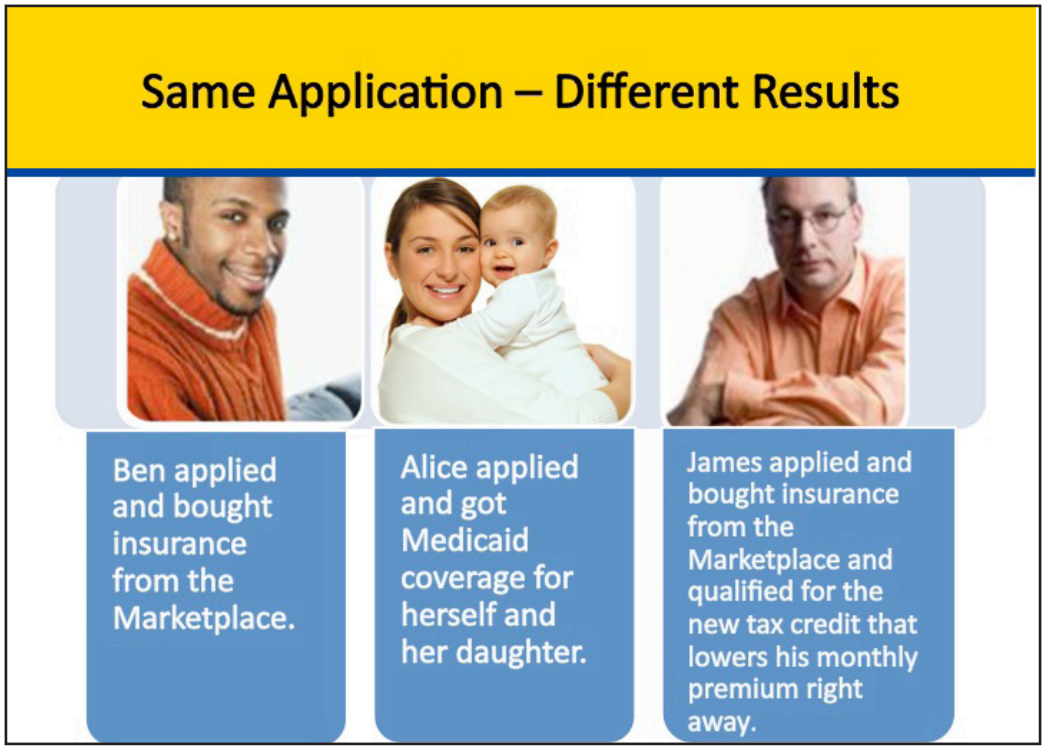
- Complete one streamlined application for
- Qualified Health Plan through the Marketplace
  - Eligibility determination for premium tax credit and reduced cost sharing
  - Medicaid
  - Children's Health Insurance Program (CHIP)
- Applications may be submitted online, by phone, by mail, or in person

SPEAKER NOTES:

States will use a single, streamlined application for coverage through the Marketplace for health insurance from private plans, the new tax credit, reduced cost sharing, Medicaid, and the Children's Health Insurance Program (CHIP). The application leads seamlessly to comparing the Qualified Health Plans and then actual enrollment.

States may use another type of application if approved by the Secretary of HHS.

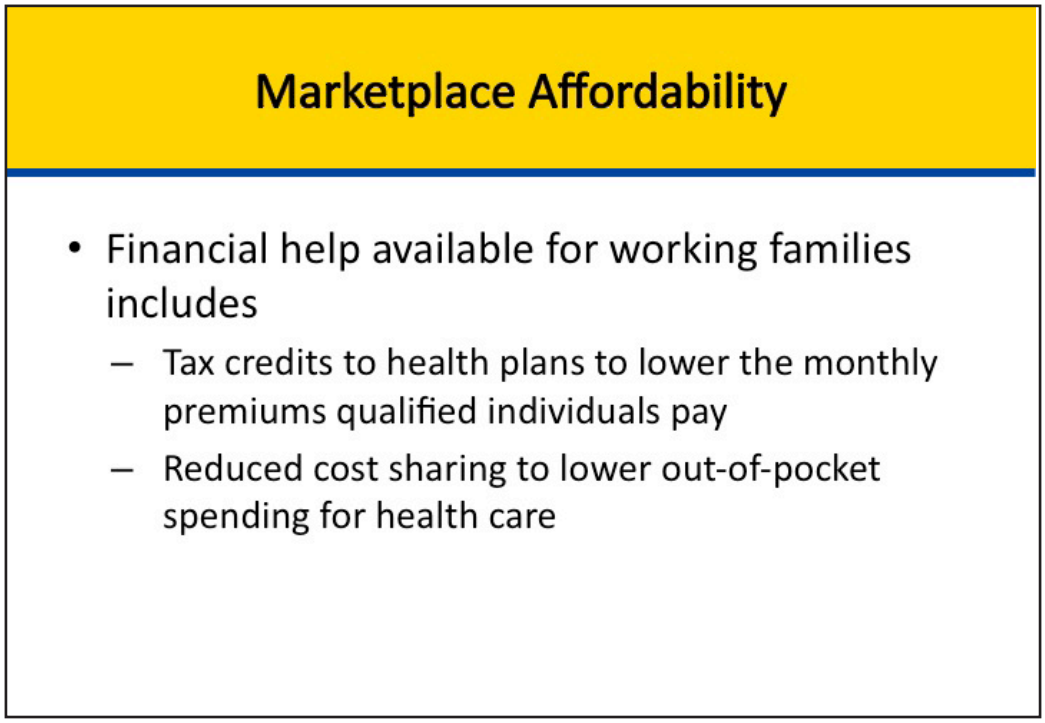
Applications may be submitted online, by phone, by mail, and in person.



SLIDE TEXT
Same Application – Different Results

- Ben applied and bought insurance from the Marketplace.
- Alice applied and got Medicaid coverage for herself and her daughter
- James applied and bought insurance from the Marketplace and qualified for the new tax credit that lowers his monthly premium right away.

SPEAKER NOTES:
The application process has been streamlined so that you can apply and find out if you, and/or members of your family, qualify for coverage from the Marketplace, the new tax credit, reduced cost sharing, Medicaid and/or CHIP. Here you see pictures of Ben, Alice and James. Ben applied and bought insurance from the Marketplace. Alice applied and got Medicaid coverage for herself and her daughter. And James applied and bought insurance from the Marketplace. He also qualified for the new tax credit that lowers his monthly premium right away.

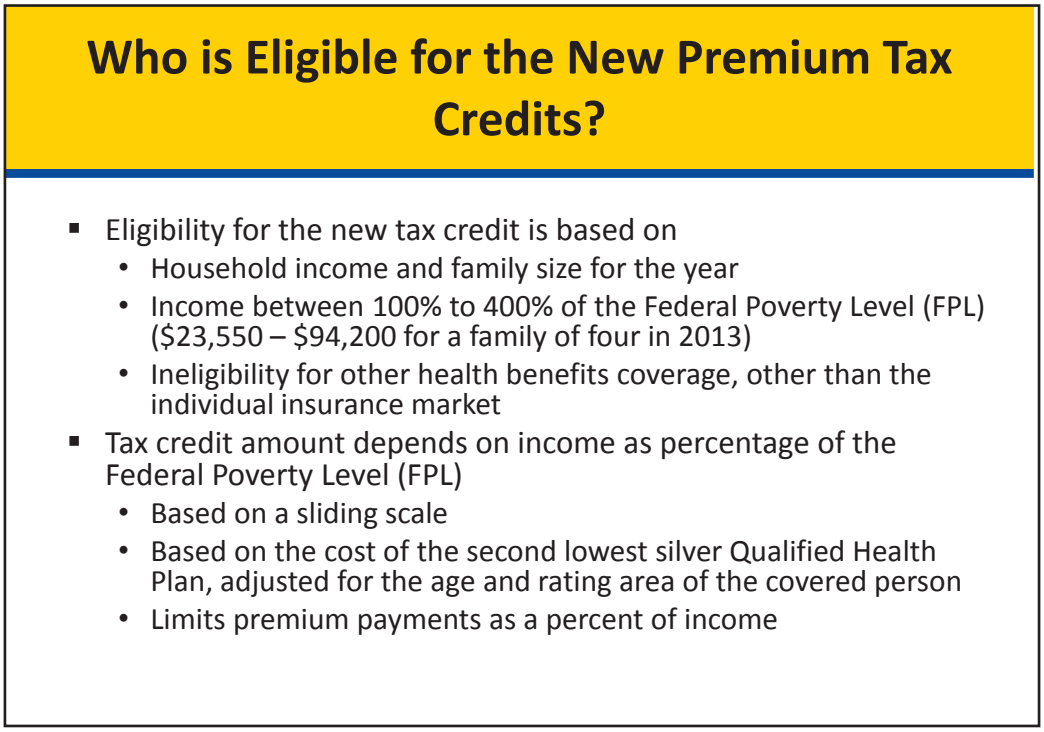


SLIDE TEXT
Marketplace Affordability

Financial help available for working families includes

- Tax credits to health plans to lower the monthly premiums qualified individuals pay
- Reduced cost sharing to lower out-of-pocket spending for health care

SPEAKER NOTES:
Coverage will be more affordable for some consumers through the new tax credits (also called Advance Premium Tax Credits) and reduced cost sharing. This financial assistance will help low income consumers who are not eligible for other insurance coverage buy insurance coverage.



SLIDE TEXT

Who is Eligible for the New Premium Tax Credits?

Eligibility for the new tax credit is based on

- Household income and family size for the year
- Income between 100% to 400% of the Federal Poverty Level (FPL) ($23,550 – $94,200 for a family of four in 2013)
- Ineligibility for other health benefits coverage, other than the individual insurance market

Tax credit amount depends on income as percentage of the Federal Poverty Level (FPL)

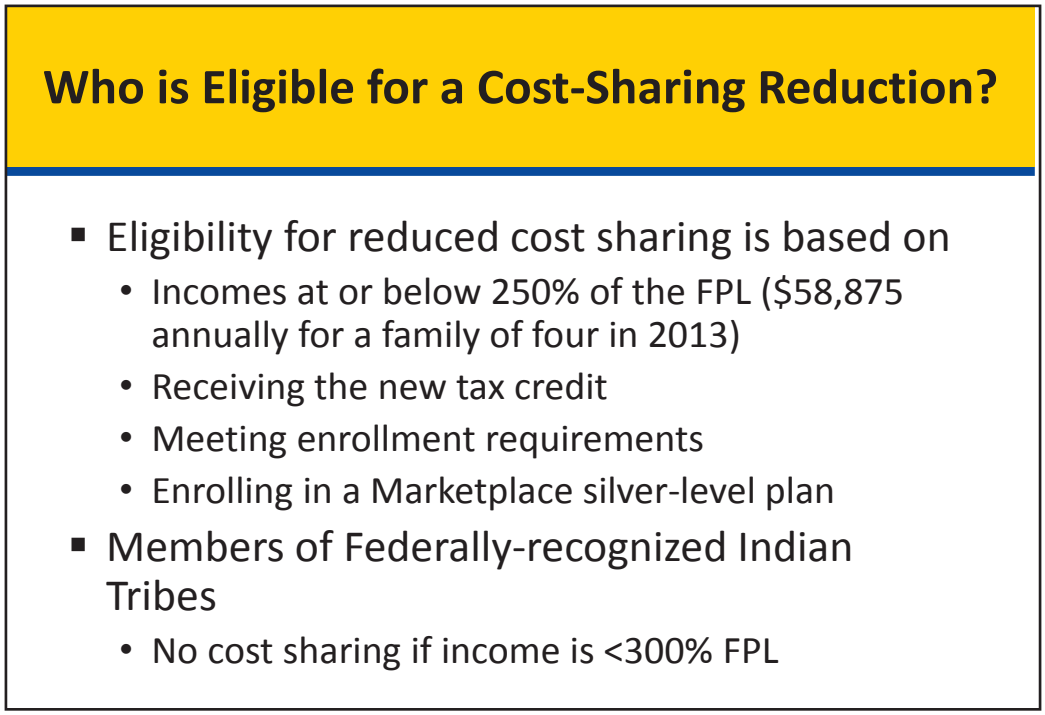
- Based on a sliding scale
- Based on the cost of the second lowest silver Qualified Health Plan, adjusted for the age and rating area of the covered person
- Limits premium payments as a percent of income

SPEAKER NOTES:

With most tax credits, you have to wait until you file your taxes to get the credit. But the new premium tax credit available through the Marketplace lets you reduce your costs right away. People who qualify can take the tax credit in the form of advance payments to lower their monthly health plan premiums starting in 2014, which can help make insurance more affordable.

The premium tax credit is generally available to individuals and families with incomes between 100% and 400% of the Federal Poverty Level ($23,550 – $94,200 for a family of four in 2013) who do not have access to certain other types of minimum essential coverage, which will make coverage much more affordable for the middle class. The Congressional Budget Office estimates that when the Affordable Care Act is fully phased in, the premium tax credit will help 20 million Americans afford health insurance.

The tax credit will be applied when you sign up for QHP coverage through the Marketplace and the payment will go directly to the insurance company. When you apply, you will provide your household income, identification to show that you are in the U.S. legally and other information. The Marketplace will determine what benefits you are eligible to receive (Medicaid, Child Health Plan Plus, tax credits). You will compare the Qualified Health Plans that are offered, each with a clear description of benefits and cost. You will buy the plan and the tax credit will be applied at that time to lower your cost. You will save more money if you choose a less expensive plan. Age-based increases in premiums are included when the premium tax credit is calculated. The advance payment of premium tax credits is reconciled at the end of the tax year. It limits the premium payments as a percent of income.



SLIDE TEXT

Who is Eligible for a Cost-Sharing Reduction?

Eligibility for reduced cost sharing is based on

- Incomes at or below 250% of the FPL ($58,875 annually for a family of four in 2013)
- Receiving the new tax credit
- Meeting enrollment requirements
- Enrolling in a Marketplace silver-level plan

Members of Federally-recognized Indian Tribes

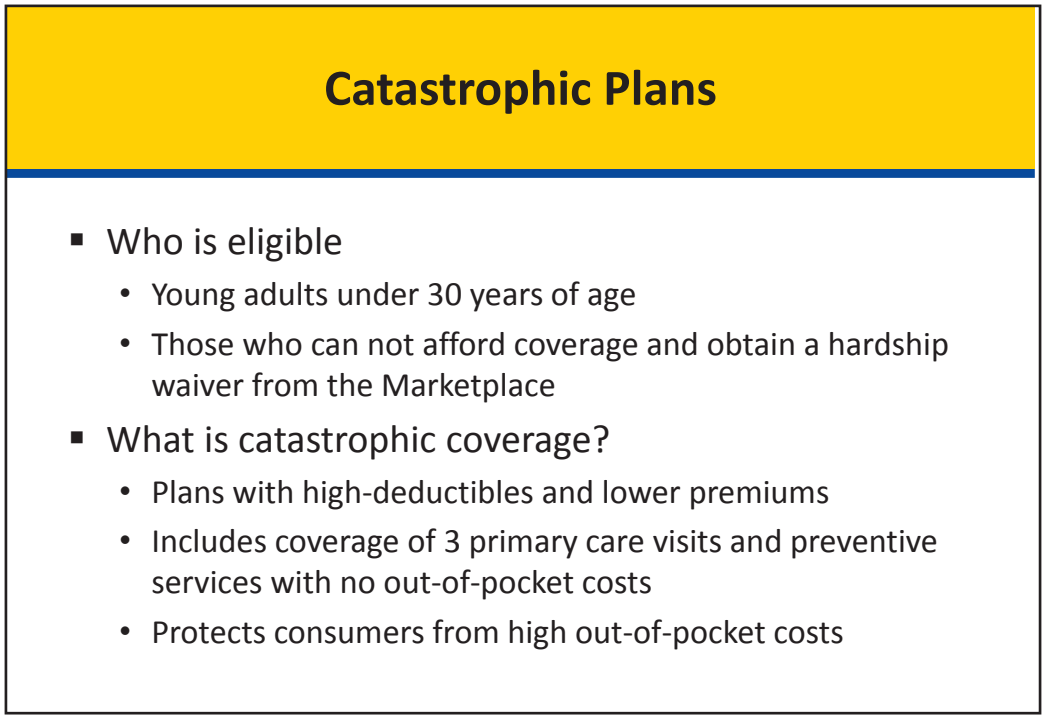
- No cost sharing if income is <300% FPL

SPEAKER NOTES:

Cost-sharing reductions are available to consumers to help them afford the insurance coverage they bought through the Marketplace.

To be eligible for cost-sharing reductions, a consumer must have a household income that is less than or equal to 250% of the Federal Poverty Level (FPL) which is $58,875 annually for a family of four in 2013; meet the requirements to enroll in a health plan through the Marketplace and receive the new tax credit; and enroll in a silver-level plan through the Marketplace.

A consumer who is a member of a Federally-recognized Indian tribe may also be eligible for special cost-sharing rules. Certain American Indians and Alaska Natives who purchase health insurance through the Marketplace do not have to pay co-pays or other cost sharing if their income is under 300 percent of the Federal poverty level, which is roughly $70,650 for a family of four in 2013 ($88,320 in Alaska).



SLIDE TEXT

Catastrophic Plans

Who is eligible

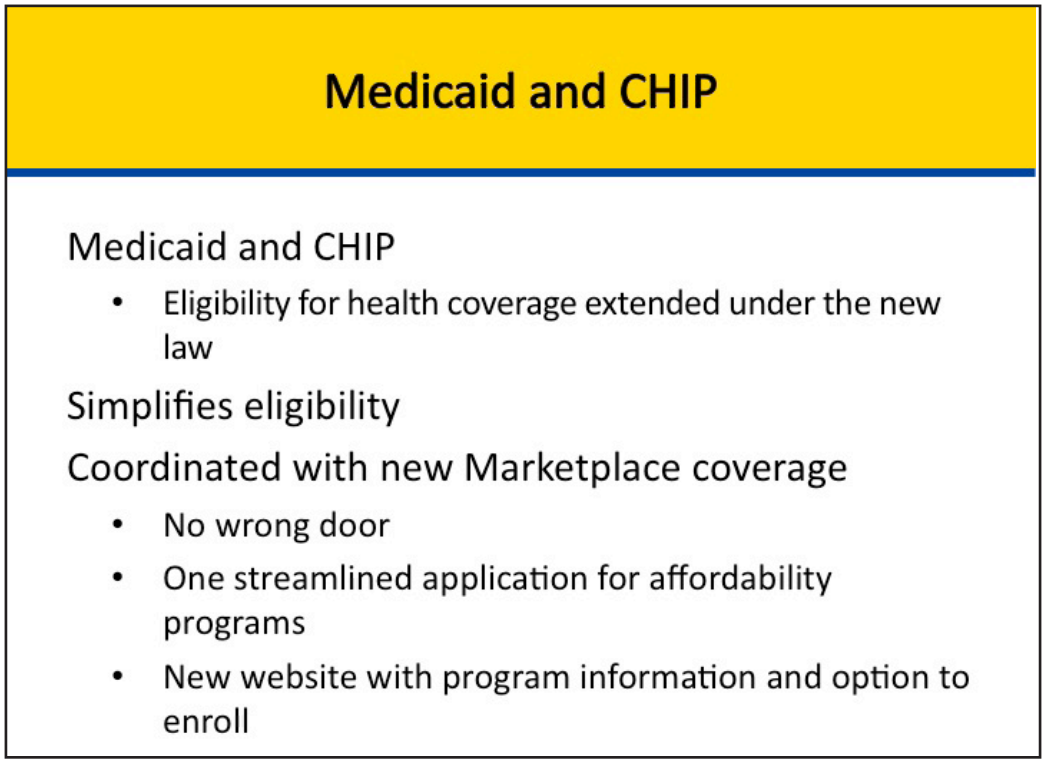
- Young adults under 30 years of age
- Those who can not afford coverage and obtain a hardship waiver from the Marketplace

What is catastrophic coverage?

- Plans with high-deductibles and lower premiums
- Includes coverage of 3 primary care visits and preventive services with no out-of-pocket costs
- Protects consumers from high out-of-pocket costs

SPEAKER NOTES:

Catastrophic plans will have lower premiums, protect against high out-of-pocket costs, and cover recommended preventive services without cost sharing—providing affordable individual coverage options for young adults and people for whom coverage would otherwise be unaffordable. The tax penalty will be explained in more detail in future materials.

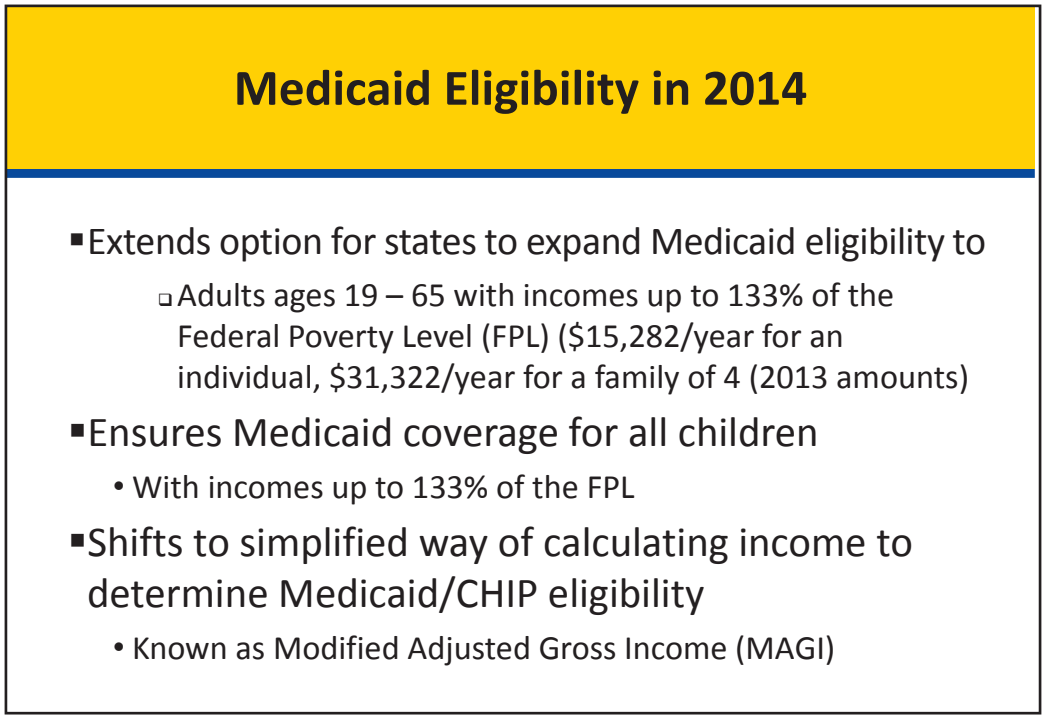


SLIDE TEXT
Medicaid and CHIP

Medicaid and CHIP
- Eligibility for health coverage extended under the new law

Simplifies eligibility
Coordinated with new Marketplace coverage
- No wrong door
- One streamlined application for affordability programs
- New website with program information and option to enro

SPEAKER NOTES:
The Health Care Law establishes a seamless system of health insurance coverage across the Marketplace, Medicaid and the Children's Health Insurance Program (CHIP). Medicaid and CHIP will serve as the foundation for this new system, providing coverage for low income adults and children, with the Marketplace serving individuals with slightly higher incomes. The new eligibility rules for all three programs will be aligned and easier to understand for families and everyone will have an opportunity to enroll in coverage using a single, unified application.



SLIDE TEXT
Medicaid Eligibility in 2014

Extends option for states to expand Medicaid eligibility to

- Adults ages 19 – 65 with incomes up to 133% of the Federal Poverty Level (FPL) ($15,282/year for an individual, $31,322/year for a family of 4 (2013 amounts)

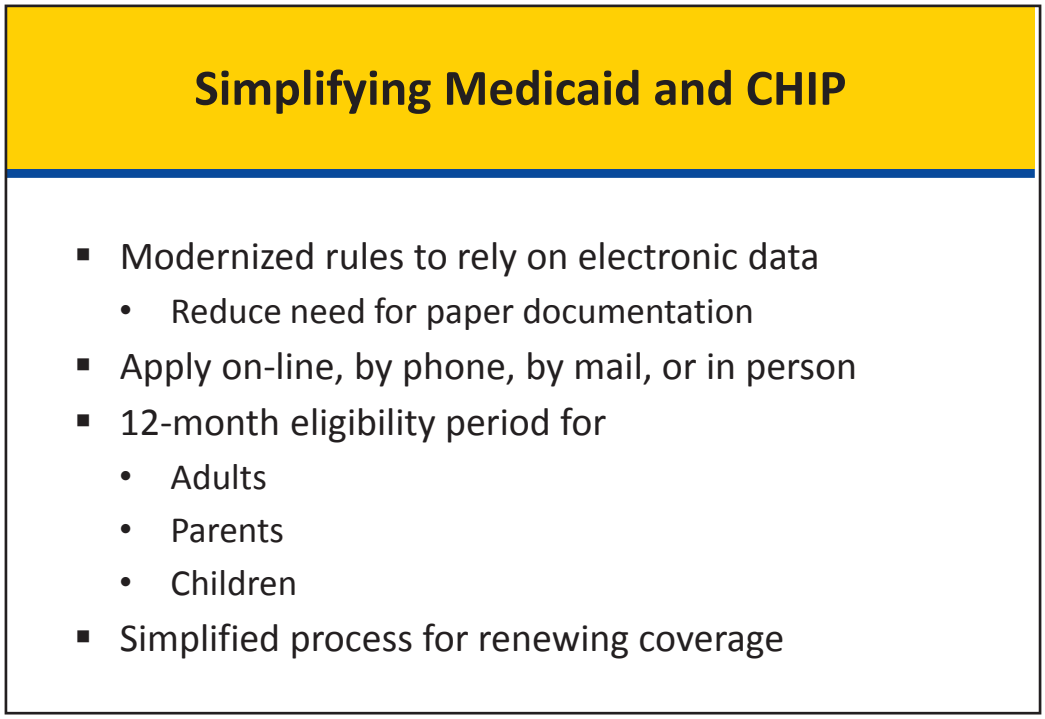
Ensures Medicaid coverage for all children

- With incomes up to 133% of the FPL

Shifts to simplified way of calculating income to determine Medicaid/CHIP eligibility

- Known as Modified Adjusted Gross Income (MAGI)

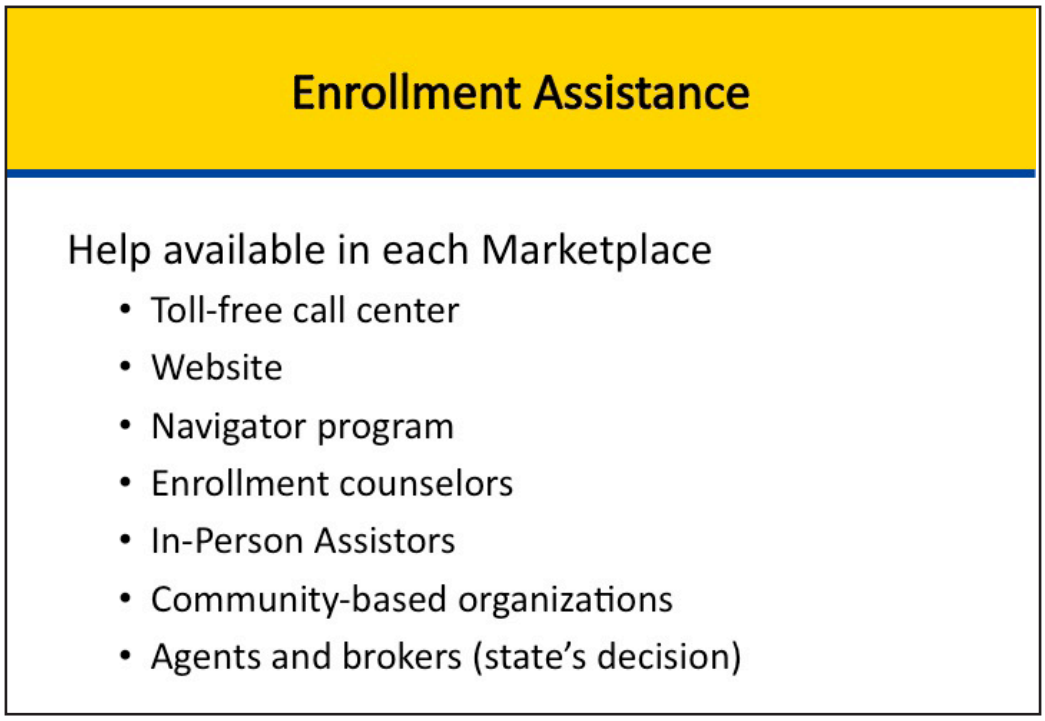
SPEAKER NOTES:
The Health Care Law fills in current gaps in coverage for the poorest Americans by creating a minimum Medicaid income eligibility level across the country. Beginning in January 2014, individuals under 65 years of age with incomes up to 133 percent of the Federal poverty level (FPL) will be eligible for Medicaid in those states that proceed with the Medicaid expansion. In addition, all children with incomes up to 133% of the FPL will be eligible for Medicaid. Those states that previously covered these children through the CHIP program will continue to receive the enhanced CHIP matching rate.
In addition, the rules for counting income for purposes of determining Medicaid and CHIP eligibility will be much simpler and easier for families to understand.
The Health Care Law makes coverage accessible to millions who would have otherwise remained uninsured.



SLIDE TEXT
Simplifying Medicaid and CHIP

- Modernized rules to rely on electronic data
- Reduce need for paper documentation
- Apply on-line, by phone, by mail, or in person
  12-month eligibility period for
  -Adults
  -Parents
  -Children
- Simplified process for renewing coverage

SPEAKER NOTES:
The new rule simplifies the Medicaid and CHIP eligibility, enrollment and renewal process in the following ways:
Modernizes eligibility verification procedures to rely primarily on electronic data sources while providing states flexibility to determine the usefulness of available data before requesting additional information from applicants, and simplifying verification procedures for states through the operation of a Federal data services "Hub" that will link states with Federal data sources (e.g. Social Security and Homeland Security).
Codifies current Medicaid policy so that eligibility is renewed by first evaluating the information available through existing data sources and limits renewals for the people enrolled through the simplified, income-based rules to once every 12 months unless the individual reports a change or the agency has information to prompt a reassessment of eligibility.



SLIDE TEXT
Enrollment Assistance

Help available in each Marketplace
- Toll-free call center
- Website
- Navigator program
- Enrollment counselors
- In-Person Assistors
- Community-based organizations
- Agents and brokers (state's decision)

SPEAKER NOTES:
If you have questions or need help applying, there are several resources that will be available, including a toll-free call center and website with plan comparison tools. There are also several programs to help you through the process of enrolling and using health insurance, including the Navigator program.
Community-based organizations, agents and brokers, and other third party assistors will also play a large role in helping people apply for health insurance coverage. The final rule lays out ways for agents and brokers to help consumers and small businesses enroll through the Marketplace if the state so chooses.
It is important to note that some of the assistance resources (Marketplace call centers and websites, and Navigators) will be unbiased and impartial, while others (agents and brokers, and issuer web sites and call centers), will not.
For information about enrolling in Medicaid or the Children's Health Insurance Program (CHIP), check with your State Medical Assistance (Medicaid). Call 1-800-MEDICARE (1-800-633-4227) to get their phone number. TTY users should call 1-877-486-2048. Or, visit www.medicare.gov/contacts and search for your state Medicaid office's contact information.

SLIDE TEXT

Navigator Program

Grant program sponsored by each Marketplace.

Navigators will

- Raise awareness about the Marketplace
- Provide unbiased information about enrollment
- Help consumers understand health plan differences
- And help submit consumers' selections to the Marketplace
- Provide culturally/linguistically appropriate information
- Give referrals
- May be an agent or a broker if standards are met
- Can't be paid by issuer for enrolling people in QHPs/non-QHPs

Other assistance also may be available beyond Navigators

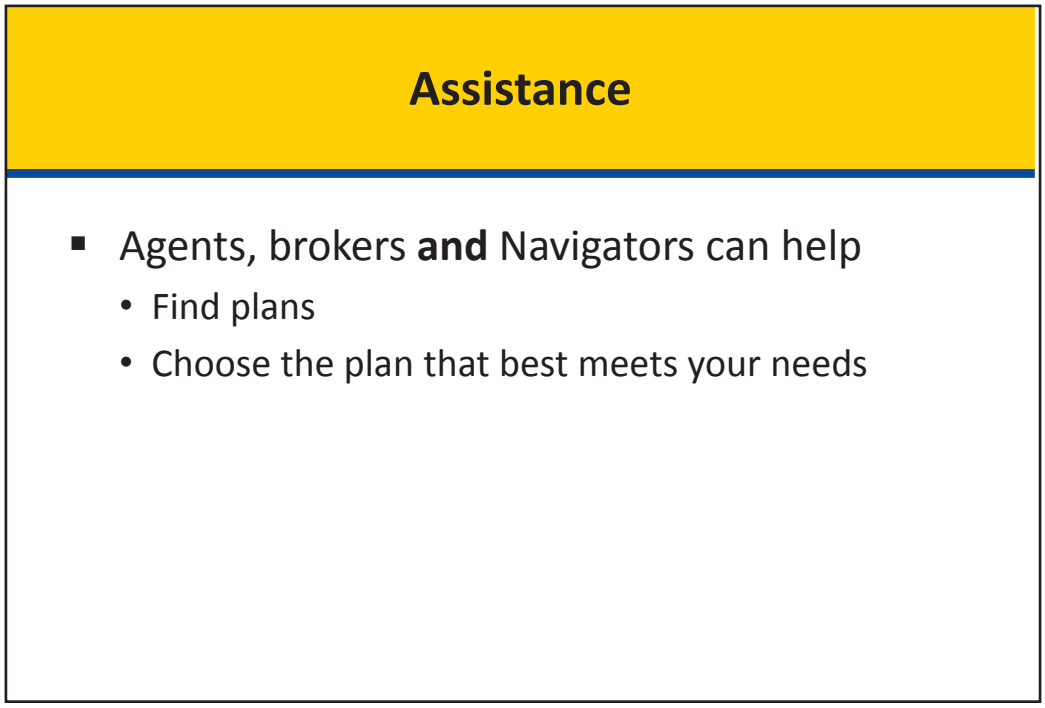
SPEAKER NOTES:

The Marketplace must establish a grant program to fund entities or individuals called "Navigators" that will provide consumer assistance. Navigators will help you understand your new health insurance options available through the Marketplace and will help you select a health plan.

The primary goals of Navigators are to raise public awareness about the Marketplace, reach out to diverse populations, help consumers understand their coverage options, and provide referrals.

To ensure that Navigators provide unbiased and accurate information, the Marketplace must develop conflict of interest standards and training programs for Navigators.

Navigators can't receive payment from health insurance issuers for enrolling consumers, employers, or employees in Qualified Health Plans or in non-Qualified Health Plans outside of the Marketplace. However, they can help consumers with other non-Navigator assisted enrollment functions, as set forth in in 42 CFR 155.220. Agents and brokers may serve as Navigators as long as all other Navigator standards are met.



SLIDE TEXT
Assistance

Agents, brokers and Navigators can help
- Find plans
- Choose the plan that best meets your needs

SPEAKER NOTES:
Agents and brokers can help employers find, choose, and enroll in coverage. The Navigator program will inform individuals and small employers about the availability of Qualified Health Plans within the Marketplace. Navigators won't actually enroll people. Navigators and their role in the Marketplace will be discussed later. NOTE: Navigators cannot receive compensation from health insurance issuers related to enrollment.

SLIDE TEXT

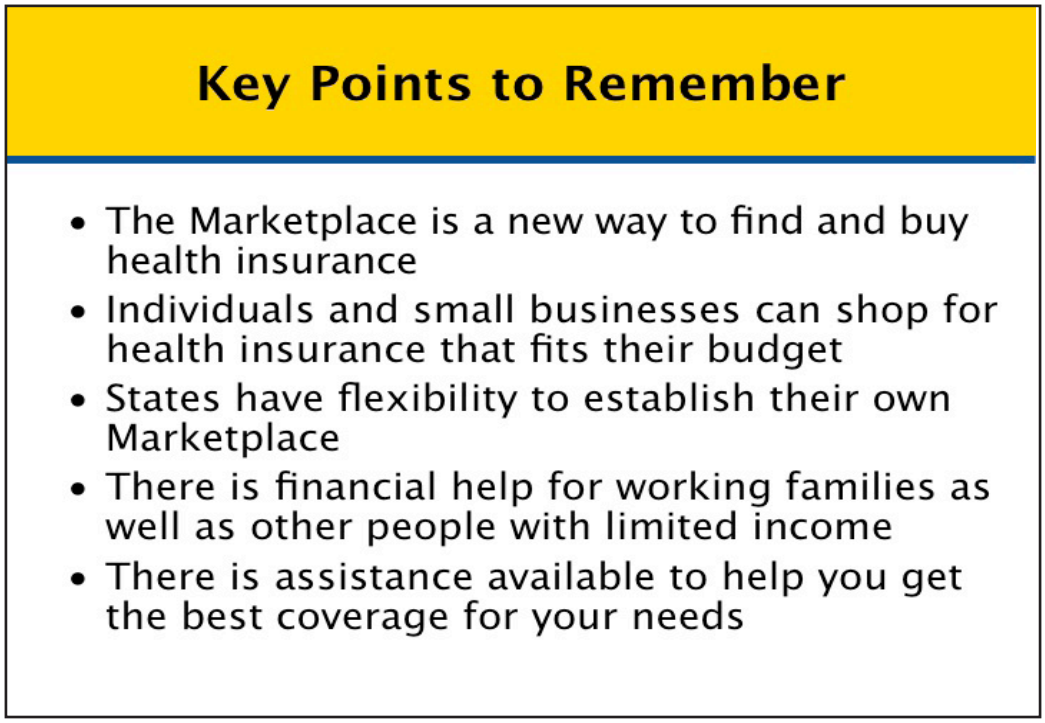
Resources Available Now at www.HealthCare.gov

Insurance Finder

- Tool to identify private and public health coverage options
- Sorts through a catalog of options
- Identifies ones that may be right for you

SPEAKER NOTES:

The Insurance Finder on www.HealthCare.gov is a tool that can help you identify both private and public health coverage options available in your area. The Finder sorts through available options to help identify the ones that may be right for you.



SLIDE TEXT

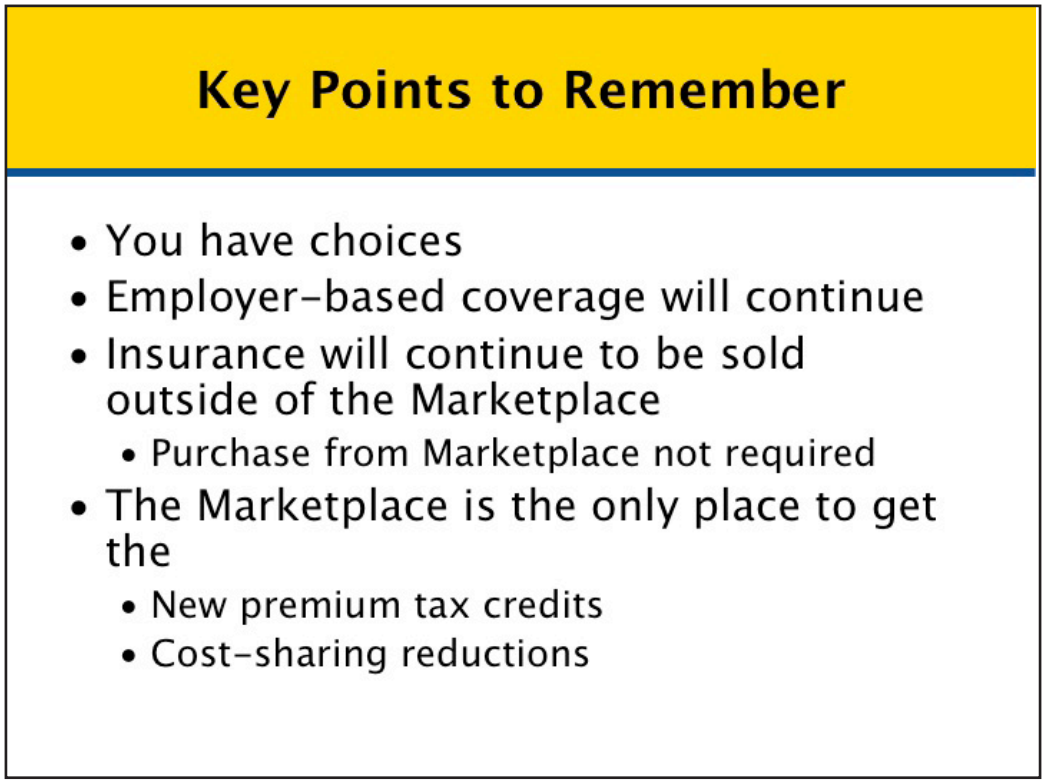
Here are some key points to remember:

1. The Marketplace is a new way to find and buy health insurance
2. Individuals and small businesses can shop for health insurance that fits their budget
3. States have flexibility to establish their own Marketplace
4. There is financial help for working families and other people with limited income
5. There is assistance available to help you get the best coverage for your needs

SPEAKER NOTES:

Here are some key points to remember:

1. The Marketplace is a new way to find and buy health insurance
2. Individuals and small businesses can shop for health insurance that fits their budget
3. States have flexibility to establish their own Marketplace
4. There is financial help for working families and other people with limited income
5. There is assistance available to help you get the best coverage for your needs



SLIDE TEXT

1. You have choices
2. Employer-based coverage will continue
3. Insurance will continue to be sold outside of the Marketplace
4. Purchase from Marketplace not required

The Marketplace is the only place to get the
-New premium tax credits
-Cost-sharing reductions

SPEAKERS NOTES:
You have choices. No one will be required to buy coverage in the Marketplace. Enrolling through the Marketplace is voluntary, employer-based coverage will continue, and insurance will continue to be sold outside of the Marketplace. The Marketplace will be the only way to access the new tax credit and cost-sharing reductions to help you with health care costs.

SLIDE TEXT

Need more information about the Health Insurance Marketplace?

- Sign up to get email and text alerts at signup.healthcare.gov
- Updates and resources for partner organizations are available at Marketplace.cms.gov/
- Like us on Facebook and follow us on Twitter!

SPEAKER NOTES:

Need more information about the Health Insurance Marketplace?

- Sign up to get email and text alerts at signup.healthcare.gov
- Updates and resources for partner organizations are available at Marketplace.cms.gov/
- Like us on Facebook and follow us on Twitter!